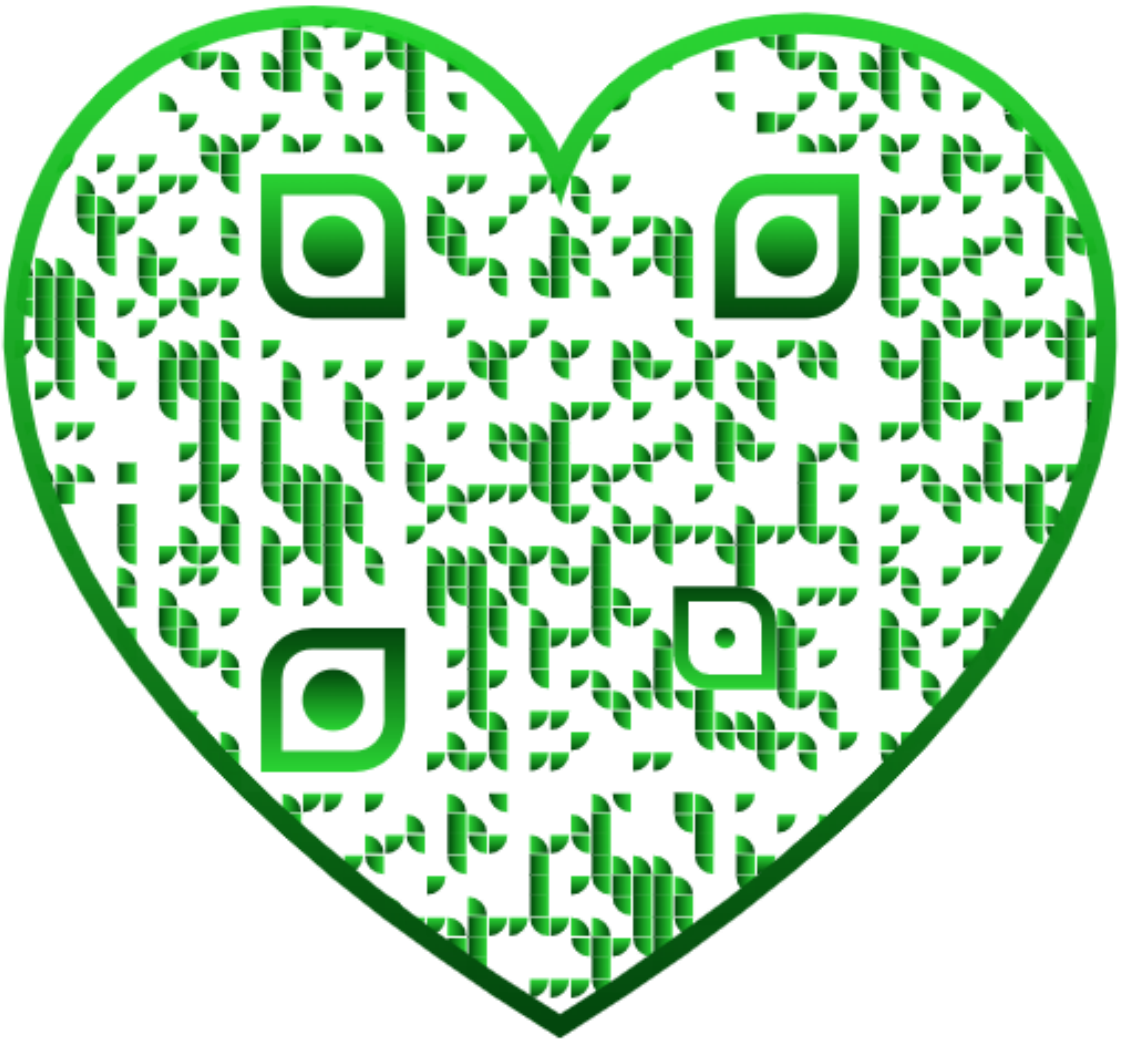
Colin A. Ross, MD

Satanic Ritual Abuse

PRINCIPLES OF TREATMENT

With an Afterword by Elizabeth F. Loftus



Satanic Ritual Abuse: Principles of Treatment
Colin A. Ross, MD
Afterword by Elizabeth F. Loftus

In recent years, the subject of Satanic ritual abuse (SRA) has incited widespread controversy, focused primarily on whether or not such abuse actually occurs. Much like child sexual abuse, SRA was initially dismissed as an isolated or even imaginary phenomenon. Although there is increasing evidence that ritual abuse does take place, clinicians working with individual patients cannot be sure whether they are dealing with fact or fantasy. Dr Colin Ross, an expert in the treatment of dissociative disorders, has encountered more than three hundred patients with memories of alleged Satanic ritual abuse. In this book, he provides a well-documented discussion of the psychological, social, and historical aspects of SRA and presents principles and techniques for its clinical treatment.

Although Dr Ross has found no evidence of a widespread Satanic network, he is open to the possibility that a certain percentage of his patients' memories may be entirely or partially historically accurate. In treatment, he recommends that the therapist adopt an attitude hovering between disbelief and credulous entrapment.

Dr Ross has encountered memories of SRA primarily among people who suffer from multiple personality disorder, and the principles of treatment he outlines here focus on such individuals. Treatment is described in terms of both general principles and specific techniques, with case examples. Ross's recommendation that the same interventions be used regardless of the percentage of memories that are historically accurate bridges the gap between clinicians who adopt a 'believer' stance and those who take a false-memory stance.

This is the most detailed and comprehensive account of SRA from a clinical perspective available to date. As reports of SRA continue to escalate, it will be a valuable resource for all practising therapists and psychiatrists.

DR COLIN ROSS is director of the Dissociative Disorders Unit at Charter Behavioral Health System of Dallas and associate clinical professor of psychiatry at Southwestern Medical Center in Dallas. He is the author of *The Osiris Complex: Case Studies in Multiple Personality Disorder*, published in 1994 by University of Toronto Press.

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COLIN A. ROSS, MD

Satanic Ritual Abuse: Principles of Treatment

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Preface

Satanic ritual abuse was a topic unknown to most people in North America as recently as ten years ago. Since then Satanic cults have been the subject of countless media reports, of which about five hundred are listed in a bibliography by Linda O. Blood entitled *Satanism and Satanism-Related Crime: A Resource Guide* (1989). When I saw my first case of apparent Satanic ritual abuse in 1986, I had never read a book or article on the topic; heard any mental-health professional mention such a case; or been to a lecture, workshop, or seminar on the subject. Since then, two academic collections of essays on Satanic ritual abuse have been published (Richardson, Bromley, and Best, 1991; Sakheim and Devine, 1992), the *Journal of Psychology and Theology* has devoted a special 1992 issue to Satanism, the *Journal of Psychohistory* has devoted a special 1994 issue to cult abuse of children, and *The New Yorker* has published a major two-part article on Satanism, in the 17 and 24 May 1993 issues (Wright, 1993a; 1993b). Additionally, dozens of conferences and workshops dealing with Satanic ritual abuse have been held throughout the United States and Canada.

Personally, I have had clinical contact with about three hundred cases of multiple personality disorder (MPD), now officially renamed 'dissociative identity disorder' (American Psychiatric Association, 1994), in which the person had memories of involvement in a destructive Satanic cult. In about eighty of these cases, I have had considerable direct involvement, as a therapist or attending physician, and in the rest I have been a participant in consultation or in group therapy. In none of these cases has the reality of the memories been objectively verified, and in several of them collateral history has proven that patient claims of Satanic ritual abuse were false. I did not seek verifica-

tion beyond the level of usual clinical history-taking because that is not my role and because I have not had the available resources or expertise. The patients cite the remoteness of the events in time, fear, and lack of resources as the reasons for not pursuing objective verification of their memories.

In order to understand this troublesome topic better, I began attending workshops on Satanism and talking to colleagues; I also began to read the available literature, and noticed that it had several peculiarities I had never before encountered in my professional reading. For one thing, as is evident from the references in this book, the literature on Satanic ritual abuse comprises more books than journal articles. Usually, in the professional literature dealing with mental-health subject areas, the reverse is true – articles far outnumber published books.

The second peculiarity I noticed, both at professional meetings and in my reading, was an extreme polarization of opinion. Despite the dearth of scientific or empirical literature, strongly worded views were expressed at both ends of the continuum, which ranged between firm belief in the reality of Satanic ritual abuse memories and skepticism about the truth of any of those memories. The reality of Satanic ritual abuse did not appear to be a subject of debate in any serious sense, and seemed, rather, to involve believers and skeptics speaking from preconceived, ideologically driven positions. Discussion focused on whether such cults really exist, which is a reasonable starting-point, but had no context and seemed to be conducted in a historical, anthropological, clinical, and law-enforcement vacuum, with little or no organized data to provide a foundation.

The books I read tended to fall into one of four categories: case-studies (Feldman, 1993; Marron, 1988; Mayer, 1991; Smith and Pazder, 1980; Spencer, 1989; Stratford, 1988; Terry, 1987; Warnke, 1972; Wright, 1994); books written from a fundamentalist perspective (Brown, 1987; Bubeck, 1991; Cooper, 1990; Larson, 1989; Michaelson, 1989; Passantino and Passantino, 1991; Schwarz and Empey, 1988) or a twelve-step perspective (Ryder, 1992); and journalistic treatments (Blood, 1994; Hicks, 1991; Johnston, 1989; Kahaner, 1988; Lyon, 1988).

Although these books contain a great deal of useful information, they are limited in so far as they discuss a small number of cases from a single-case perspective or tend to be contaminated by the ideological biases of their authors. In none of this literature did I find a comprehensive context for thinking about the problem of Satanism. Realizing that an adequate discussion would have to be grounded in detailed knowledge

of the clinical reality of ritual abuse cases, I sought in vain for a comprehensive study of such cases. The case descriptions tended to be brief, vague, or skewed by the biases of the authors, and none exhibited adequate psychological depth.

Similarly, in searching for a book that placed Satanic ritual abuse in a historical context and provided scholarly discussion of the history of known destructive and human-sacrifice cults, and secret societies, I found no single work that contained what I was looking for. Additionally, I was unable to locate a history of Satan that brought theological and cultural knowledge to bear on discussions of contemporary Satanism. It seemed to me that several indispensable contexts were absent from much of the discussion of Satanic ritual abuse, and that, without these contexts, the ungrounded, unprofitable, and polarized debate was likely to continue. Finally, and most important for my clinical work, no sufficiently detailed discussion of how clinicians can treat Satanic ritual abuse cases was available in the literature.

In deciding to write this book, I saw the necessity of correcting the contextual deficiencies but was also aware that I am not qualified as a theologian, historian, expert on non-Satanic cults, or anthropologist to the degree that is required for the task. Dealing adequately with the complex subject-matter in the first section of this book would require a PhD in three or four different disciplines, an achievement far beyond the grasp of any single individual. Nevertheless, background reading completed, I set out to write a book that would provide a context sufficient for the clinician's needs. I try to do one main thing in this book: to establish that good clinical work requires a balanced perspective, free of the limitations imposed by adherence to either end of the ideological continuum. Such a perspective acknowledges that, while there is no evidence of a widespread secret network of Satanic ritual abuse, it is possible that a certain percentage of Satanic ritual abuse memories are historically accurate, or contain accurate elements.

Within the limitations of our current knowledge, no one can measure with any factual accuracy the extent of organized Satanism. It is my opinion that many of the Satanic ritual abuse memories described by the patients I treat are confabulated and comprise things that never actually happened. However, I am cautious in this opinion because I cannot know for sure that it is correct. I assume, for the sake of discussion, that 10 per cent of the content of such memories could be historically accurate and based on distorted recall of childhood participation in small Christian cults; small, isolated groups of Satanists; deviant elements of

the Ku Klux Klan; pornography; or other forms of abuse that a child could misinterpret as Satanic.

In this book, I describe a treatment method for Satanic ritual abuse survivors with MPD in which the interventions can be used regardless of what percentage of the memories are real. *Satanic Ritual Abuse* has a clinical focus, and the necessary non-clinical background it provides is unavoidably incomplete. Writers from other disciplines should consider producing scholarly works on the history and anthropology of Satanism and destructive cults that would adequately explore the material reviewed in the first section of this book.

The objective reality of Satanic ritual abuse memories is primarily a sociological and law-enforcement question and cannot be answered by clinicians. None the less, clinicians treating this population need guidelines that will encourage grounded, helpful therapeutic interventions, free from the extremes of belief and skepticism. To this end, *Satanic Ritual Abuse* endeavours to reduce the unproductive polarization of debate about Satanism within the mental-health field, and in society, at large, by criticizing both extremes; to provide a wider context for discussion; to suggest specific research studies that are required; to correct key conceptual errors in the field; and to describe the clinical reality of Satanic ritual abuse cases.

In this book, I provide clinicians with guidelines for how to recognize and treat such cases. Because my clinical experience is limited almost entirely to Satanic ritual abuse survivors with MPD, I deal predominantly with those patients. This focus is consistent with clinical needs because most patients who report such memories have MPD. (I use the abbreviation 'MPD' in this book, rather than the new term 'dissociative identity disorder,' because the former term is still more familiar to most readers.) However, the clinical focus also addresses the broader debate, establishing a context that is too often absent or distorted by misinformation. In describing a balanced clinical treatment of Satanic ritual abuse cases, the clinical material creates a way of understanding and treating these cases that can be effective regardless of what percentage of the memories are real, and this strategy also reduces the polarization into opposing camps of believers and skeptics.

Throughout this book, I set contemporary Satanic ritual abuse in a context of Judaeo-Christian culture: my perspective on Satanism is rooted in themes of dissociation, dualism, and projection, which are at the heart of our history and which are within my expertise as a psychiatrist. I see the sociology of the controversy surrounding Satanic ritual

abuse as a contemporary enactment of the myth of Satan, which is the deepest myth of Judaeo-Christian culture.

The question of the extent to which the symbolism and mythology of Satan are being acted out in Satanic human sacrifices in North America in the late twentieth century is not answered in these pages, and cannot be. As I said earlier, at least 10 per cent of the reported memories could be real: no one knows where the actual figure falls, and no benefit can be derived from making premature estimates. Similarly, no attempt is made in this book to produce a formal definition of Satanic ritual abuse. There are too many forms and levels of Satanism for one definition to be all-encompassing, and, when it comes to the most extreme form of Satanism – multigenerational orthodox Satanic cults – it is clear what we are talking about. These cults, if they exist, are secret, highly organized, and devoted to human and animal sacrifice, sado-masochistic ritual sex, child abuse, and other crimes, which are committed during ceremonies involving pentagrams, robes, chanting, Satanic theology, candles, goblets, daggers, and other paraphernalia.

As initial reading about Satanic ritual abuse, I recommend *The Satanism Scare* (Richardson, Best, and Bromley, 1991), because I find it to be the best collection of essays written from a skeptical viewpoint, and *Out of Darkness: Exploring Satanism and Ritual Abuse* (Sakheim and Devine, 1992), which is the best collection of essays from a believer perspective. For law-enforcement information and a governmental perspective, I recommend *Satanism and Occult-Related Violence: What You Should Know* (Langone and Blood, 1990); *Report of the Virginia State Crime Commission Task Force Study of Ritual Crime* (Gray, 1992); the Office of Criminal Justice Planning, State of California, *Research Update* 6/1 (Winter 1989–90); and the report on Satanic crime prepared by Kenneth Lanning of the FBI, entitled *Investigator's Guide to Allegations of Ritual Child Abuse* (1992). Information for ordering these materials is provided in chapter 12.

Special issues of three academic journals contain papers on Satanic ritual abuse: *Journal of Psychology and Theology* 20 (1992); *Child Abuse and Neglect* 15 (1991); and the *Journal of Psychohistory* 21 (1994). Academic papers by Ofshe (1992) and Nurcombe and Unutzer (1991), and the paper by Young, Sachs, Braun, and Watkins (1991) are worthy of attention, as is a popular article by Whitley (1991).

Those who are skeptical that Satanic ritual abuse could be real should read Dzeich and Schudson's book on how U.S. courts deal with child sexual abuse, entitled *On Trial: America's Courts and Their Treatment of Sexually Abused Children* (1991). Dzeich and Schudson describe a non-

Satanic case which resulted in conviction. The *Country Walk* case from Miami, Florida, resulted in a prison sentence without chance of parole until the year 2150 for Frank Fuster. Dzeich and Schudson write: 'The victims, predominantly infants, toddlers, and preschoolers, were subjected to sexual abuse and pornography; to being drugged and terrorized by sadistic games, disguises, and animal slaughter; and to having to drink urine and consume excrement. Authorities estimated the couple [Frank and Iliana Fuster] had access to as many as fifty children; but by the time the case reached court, only eight were able or permitted by parents to testify' (p. 78). Fuster's wife corroborated the children's stories under oath.

The fact that Frank Fuster was convicted for acts that include all the alleged activities of Satanists except human sacrifice proves that such acts can take place and have occurred in North America in recent years. Though there is no evidence that he belonged to an organized cult, Frank Fuster had prior convictions for murder and child molestation, though these facts were not admissible in court and not known to the jury.

Other media sources provide hints but no proof that actual Satanic ritual abuse may be occurring in the Western world today. An article in *The International Herald Tribune*, 30 December 1993 (Anastasi, 1993; Blood, 1994), describes the arrest of a group of Satanists in Greece. Four soldiers in their twenties and an eighteen-year-old woman confessed to the ritual murder of two humans during Satanic ceremonies: the victims were a fourteen-year-old girl and a twenty-seven-year-old woman. According to the charges, the group carried out 'rituals in tribute to a satanic god, rituals that mostly involved drinking and sex orgies. They would then restrain their victims with chains and handcuffs, torture them, and in two cases put them to death with daggers and a gun.' The arrests occurred because one of four girls being prepared for sacrifice on 25 December 1993 'broke down and reported the rituals to police.'

Although this case has not yet gone to trial, charges include premeditated murder, torture, conspiracy, arson, and illegal possession of firearms. Depending on its outcome, this case suggests that some memories reported by Satanic ritual abuse survivors in treatment in North America could be real.

In their book *Missing Children: Rhetoric and Reality*, Forst and Blomquist (1991) review the statistics on missing children in North America. The authors' intention is to counter the fear that thousands of children go missing every year in the United States; although they are committed

to the view that the number of cases per year indicates that the problem is not widespread, and their bias is against hysteria or exaggeration, their figures are none the less alarming.

In 1983, the U.S. Department of Health and Human Services estimated the number of missing children in the United States at 1.5 million a year. The vast majority of these children were only *technically* missing, since they returned home within a few hours or days, with or without police assistance. A disparity in estimates is apparent within the narrower category of kidnapping: in 1985, the executive director of the National Center for Missing and Exploited Children estimated that between 4,000 and 20,000 children are kidnapped by strangers in the United States per year; in 1981, the FBI investigated only 35 child kidnappings, and, in 1986, only 57 cases. We have no precise accounting of the number of children who go missing permanently in North America per year.

The *National Statistical Survey of Runaway Youth* estimated that 733,000 youth ran away from home in the United States in 1975, and the figure was set at one million per year by the commissioner for the Administration of Children, Youth, and Families in testimony before a U.S. Senate subcommittee in 1990.

In contrast to the number of children who potentially could be kidnapped into multigenerational orthodox Satanic cults is the figure of *confirmed* cases of children having been kidnapped and murdered by a stranger in the United States: this figure ranges between 52 and 156 children per year, according to Forst and Blomquist – conservatively, about 5,000 children since the end of the Second World War. The figure the authors derive for the percentage of kidnapped and missing children who are murdered is 2.8 per cent, a remarkably precise estimate, given the amount of noise in the data.

Forst and Blomquist describe the study from which the estimate of 2.8 per cent is derived: the study was done in Jacksonville and Houston and examined 1,299 cases of child kidnapping by non-family members in those two cities, as detailed in the 1986 report of the National Center for Missing and Exploited Children. Inexplicably, only 211 cases were included in police records, but of these 211, 54 per cent involved sexual assault, and 2.8 per cent murder.

If the 211 cases in police records were a representative sample of the 1,299 cases, then 36 children were kidnapped and murdered by strangers in two U.S. cities in one year, compared with a total of 57 kidnappings with all outcomes investigated by the FBI in the entire country in 1981. One must conclude from these figures that estimates of the num-

ber of children who are kidnapped and murdered per year in North America are imprecise; by extension, one could also conclude that it is logistically possible for a number of undetected ritual murders to be conducted per year in North America.

In writing this book, I have learned the most from my patients. It is impossible to work intensively with cases of multiple personality disorder without becoming deeply troubled by Satanic ritual abuse. I would like to thank Charter Behavioral Health System of Dallas for providing me a supportive environment for the treatment of MPD. I have learned a great deal about ritual abuse because of the opportunity Charter Medical Corporation has provided. Many different staff members at Charter Behavioral Health System of Dallas have been interested in learning about MPD and Satanic ritual abuse, none more than Dr Howard Miller. He and the other psychiatrists working on the Dissociative Disorders Unit – Dr Richard Roskos and Dr Andrew Brylowski – have, among other things, kept me from being overwhelmed with clinical work. I owe a special debt to Gay Fite for recruiting me to Charter, then working so hard as program administrator of the Dissociative Disorders Unit, and to Aleen Davis for her personal and administrative support.

I would like to thank Dale Whitmer and Tere Kole for creating a private office environment that would be hard to improve on. Dale Whitmer has been especially helpful in obtaining background material and in the preparation of the manuscript.

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SATANIC RITUAL ABUSE: PRINCIPLES OF TREATMENT

Women's rights groups denounced a letter written by religious broadcaster Pat Robertson opposing the Equal Rights Amendment. Iowans vote Nov. 3 on whether to add the equal rights provisions to the state constitution. Mr. Robertson, a 1988 Republican presidential candidate, said in the letter last month that the Equal Rights Amendment is part of a 'feminist agenda' that 'is not about equal rights for women.' Instead, he wrote, 'it is about a socialist, anti-family political movement that encourages women to leave their husbands, kill their children, practice witchcraft, destroy capitalism and become lesbians.'
The Dallas Morning News, 26 August 1992, p. 9A

What would you say, by the way, if I told you that all of my brand-new prehistory of hysteria is already known and was published a hundred times over, though several centuries ago? Do you remember that I always said that the medieval theory of possession held by the ecclesiastical courts was identical with our theory of a foreign body and the splitting of consciousness? But why did the devil who took possession of the poor things invariably abuse them sexually and in a loathsome manner? Why are their confessions under torture so like the communications made by my patients in psychic treatment? Sometime soon I must delve into the literature on this subject.
Sigmund Freud, Letter to Wilhelm Fleiss, 17 January 1897

I have ordered the *Malleus maleficarum*, and now that I have put the final touch on the infantile paralyses, I shall study it diligently ... I dream, therefore, of a primeval devil religion with rites that are carried on secretly, and understand the harsh therapy of the witches' judges. Connecting links abound.
Sigmund Freud, Letter to Wilhelm Fleiss, 24 January 1897

Legend study is a most revealing area of such research because the stories that people believe to be true hold an important place in their worldview. 'If it's true, it's important' is an axiom to be trusted, whether or not the lore really *is* true or not. Simply becoming aware of this modern folklore which we all possess to some degree is a revelation in itself, but going beyond this to compare the tales, isolate their consistent themes, and relate them to the rest of the culture can yield rich insights into the state of our current civilization. Such is the premise of this book, and from it derives the method which it follows.
Jan Harold Brunvand, *The Vanishing Hitchhiker* (1981), p. 2

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I
The Historical and Social Background

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1

Secret Societies throughout History

In trying to determine the best therapeutic approach to Satanic ritual abuse, it is essential to take a historical perspective. Secret societies practising rituals and atrocities have existed throughout human history, and many are well documented. On the basis of the historical record, it is possible that Satanic human sacrifice cults could be active in North America in the 1990s. Thus, even though we do not know whether such cults actually exist, in treating patients making claims of Satanic ritual abuse, it is important to bear in mind that nothing they describe is without historical precedent. Such perspective is essential because extreme skepticism tends to destroy empathy and obstruct the formation of a treatment alliance.

From a clinical point of view, the purpose of reviewing the history of destructive cults is this: the clinician needs to *consider* the possibility that a component of the Satanic ritual abuse memories could be real in order to be able to enter into the patient's inner world, understand it, and direct the patient towards health and recovery. The clinician in denial of the reality of human atrocity is at risk of disconnection from the patient and failure to form a working relationship. In the clinical section of this book, I describe how to maintain a balance between being absorbed too far into the patient's inner world and being pulled too far out of it into a countertherapeutic pseudo-objectivity.

Of the several arguments against the reality of Satanic ritual abuse, the main one is that no bodies have been found. This absence of conclusive physical evidence provides an overwhelming and serious problem for believers in 'the cult': there should be at least some objective, verifiable evidence available if such cults exist. A secondary argument – that there is no historical evidence for the existence of widespread Satanic human sacrifice in the past – is faulty for several reasons.

While documentation of the widespread existence of *Satanic* human sacrifice cults is lacking, evidence of other forms of systematic human sacrifice is available. Two examples in modern history are the Catholic Inquisition, a human sacrifice cult of a religious–theological nature, and the Third Reich, a human sacrifice cult of a military–political nature. (In calling the Inquisition and the Third Reich *cults*, I am using the word in a broad, informal, and unscholarly sense, to mean an organized group driven by a well-elaborated theological doctrine, which for the Nazis was Aryan racial mysticism.) The fact that the Catholic Inquisition and the Third Reich were both run by middle-class, Caucasian, educated individuals from Judaeo-Christian cultures suggests that it is psychologically possible for ordinary middle-class citizens to be perpetrating such crimes in North America today, especially given the high level of violence in contemporary Western societies.

Below I describe a number of secret societies from throughout history, many of which practised some form of ritual murder. My purpose in doing so is not to offer a scholarly treatise on documented secret societies but rather to establish that such deviant cults have actually existed in human history, thereby providing a necessary context for mental-health professionals and the general reader. In this general account, I rely principally on two books, *A History of Secret Societies* by Arkon Daraul (1961) and *The Occult Conspiracy* by Michael Howard (1989). Howard pushes his conclusions beyond his evidence in order to support a conspiracy theory, but nevertheless his book contains interesting information.

The Castrators of Russia

Is it possible that, in the nineteenth century, thousands of Russian men, including many influential and highly placed people whose names are known, voluntarily agreed to castration in order to gain membership in a widespread cult? One would think not, but it is true.

According to Daraul, the Sect of the Skoptsi, as it was called, was founded in about 1757 among members of the Sect of the Flagellants. Christian flagellants – individuals who flog and abuse themselves physically in order to attain an ecstatic mystical state – have been known since the early centuries A.D. The Russian government became aware of the Skoptsi in 1771, and the first member to be prosecuted was a peasant named Andrei Ivanov. He was sentenced and banished to Siberia, where he was thought to have died, but Ivanov's assistant, Kondratji Selivanov, remained free and fled to the district of Tambov.

Selivanov, overweight, and devoid of facial hair as a result of his ritual castration (loss of the testicles reduces the level of male hormones required for facial-hair growth), was arrested in Moscow in 1775. He was banished to Siberia but later escaped; in the interim, the government banned the cult's practices. However, in 1797, Selivanov returned to Moscow and succeeded in having an audience with the Tsar, after which he was sent to a mental asylum. Undaunted, Selivanov continued to seek political position and influence, which he was able to attain when Alexander I became Tsar of Russia. Alexander was highly influenced by Baroness Krudner, who would be a New Age mystic if she were alive today. She introduced Selivanov to the aristocracy and greatly facilitated the expansion of his cult's influence and power. In contemporary terminology, we would say that the Skoptsi infiltrated high-level business and government.

Like contemporary cult leaders, Selivanov was soon living in a large mansion, which was variously called 'the House of God,' 'New Jerusalem,' and 'Heavenly Zion.' Selivanov came to be regarded as a reincarnation of Jesus and was thought to have been Peter III in a previous life. He also had a prophet named Shilov who had foretold his coming.

According to Daraul, the cult still has an active membership in the Balkans, Lebanon, and Turkey, although the doctrine has been modified so that members are allowed to father two children before they are castrated. Subsequent to Selivanov's death in 1832, the cult spread widely throughout Russia, until mid-century, when hundreds of Skoptsi were arrested by Tsar Nicholas and transported to Siberia. Entire guilds, such as hackney-carriage drivers and carpenters, were recruited to the cult, and one membership count made in 1815 listed 56 people of assorted ranks, 148 merchants, 220 citizens, 2,736 peasants, 119 landowners, and 443 military personnel. The Skoptsi increased their numbers many-fold in later decades, though the exact maximum membership is not known. One set of records includes a tally of castrations by knife (164), razor (108), hatchet (30), scythe (23), and a miscellaneous category, including iron, glass, and tin (17). It was estimated that 40 per cent of members were female.

During government crack-downs on the cult in the second half of the nineteenth century, numerous wealthy defendants, including millionaires, were brought to trial. In the course of the legal proceedings, detailed descriptions of the sect's rituals emerged. Ceremonies were usually held on Sunday evenings, led by one or more cult prophets, with ritual frenzy achieved through the singing of hymns. Cult leaders would

then enter trances, and make prophecies that were transcribed by other members. Following this, frenzied dancing resembling the spirit-possession dancing of circumpolar shamans took place, which in turn led to the 'Baptism by Fire' of an initiate.

The 'Baptism by Fire' was the ritual castration, and it is thought, but not proven, that ritual cannibalism of the testicles may have been part of the initiation. The members wore ceremonial costumes and met in carefully designed and specially constructed buildings. Special terminology existed to describe different ranks in the cult, with non-castrated members being called 'donkeys.' According to cult beliefs, the castration was called 'the Baptism by Fire' because it was originally done with a red-hot iron, until less painful methods were substituted.

The Skoptsi had many of the structural features of contemporary destructive cults, including a hierarchical leadership, with a charismatic prophet at the top; elaborate mystical doctrine identifying the leader as Jesus returned; accumulation of wealth and political influence; stages of initiation; and special costumes, buildings, terminology, and rituals.

The existence of such a bizarre and deviant cult as recently as the nineteenth century should temper our skepticism about the possibility of Satanic ritual abuse in the 1990s.

The Assassins

The cult of the Assassins illustrates several characteristics of documented secret societies. It has existed for almost a thousand years, with a membership estimated at 40,000 to 70,000 at the end of the eleventh century. The cult's ongoing existence was documented in a British trial held in Bombay in 1866, and derivative organizations are thought to be active at present. The Assassins were extremely well organized militarily and successfully carried out numerous difficult assassinations.

Daraul describes the origins of the Assassins as stemming from the split of Islam into two factions in the seventh century, with the orthodox branch following Muhammad, and the Shiahs regarding Ali as Muhammad's first successor. From early on, the Shiahs relied on secrecy in their organization and initiation. They formed a university in Cairo which was heavily endowed from many sources, including an annual donation of a quarter of a million gold pieces from the Caliph. Although modelled on other Arab universities, the Abode of Learning was really a cult recruitment and training centre. Students passed through nine degrees of initiation, each accompanied by oaths and rituals. The doctrine

revealed to ninth-level initiates was that only action mattered, and only the chief of the sect knew what made certain actions necessary.

The secret society was in a state of dissolution until it was revived by Hasan, the son of Sabah, a prior leader of the Assassins. Hasan died in 1124, at the age of ninety. Hasan, Omar Khayyam, and Nizam-ul-Mulk had been friends at university and had agreed to help one another's careers in the future; this pledge of support eventually resulted in Hasan's being given a court position, and Omar's being given a pension by Nizam. However, a political falling out with Nizam led Hasan to flee Persia and set up headquarters in a hidden valley, where he began to recruit members for an assassination cult.

Hasan used a recruitment technique that contemporary destructive cults call 'love bombing.' The new recruit is bombarded with attention, affection, positive feedback, and the company of attractive young members of the opposite sex. Hasan's method was to choose ten or twelve young men at a time, then have them drugged and transported to his headquarters. The youths would wake to four or five days of wine, sexual attention from beautiful women, and luxury, after which they would proclaim in Hasan's presence that they had been in paradise. The rigorous training would begin thereafter.

Hasan also used terror. One such technique was to construct a special chamber in the floor, place a trainee in the chamber with only his head above ground, cover the head with blood, and have the talking head displayed to the new recruits. Hasan would then say: 'You have seen the head of a man who died, whom you all knew. I have reanimated him to speak with his own tongue.' Later the man's head would be cut off and displayed to the recruits.

Hasan established his mountain fortress of Alamut in 1090 by means of political trickery and extortion, and within two years an assassin had murdered Nizam-ul-Mulk. Subsequently, the followers of Hasan became active as hired mercenaries for both sides of the Crusades, including allegedly carrying out the contract murder of Conrad of Montferrat for Richard the Lionheart. Details of the recruitment and training methods of the Assassins became known after Alamut was taken by the Mongols, and the documents in the fortress library were studied and summarized.

Daraul quotes an Orientalist scholar who believes that the structure of many European secret societies, including the concept of degrees of initiation, was derived from the Assassins. For many centuries the Assassins carried out murders over a wide area extending from the Middle East into Russia and China; clearly, then, there is a historical precedent for the

existence of a widespread, secret, highly organized cult carrying out numerous murders, and we know that the members carrying out the murders were carefully trained.

The Illuminati

A secret society called the Roshaniya, or 'Illuminated Ones,' is known to have flourished in Afghanistan in the sixteenth century, and may have existed for several hundred years before that. The first identified leader of the cult was Bayezid Ansari, who gathered together a group of fifty disciples over a period of three years and then moved his headquarters into the mountains of Afghanistan. From there he conducted a series of highly successful military actions, which brought the cult into conflict with the ruling Moguls.

There were eight degrees of initiation in the Roshaniya, the highest of which was called 'malik,' or king. Although the inner workings of the cult are not described in any detail by Daraul, he does point out that the initiations involved meditation; repetition of special phrases; and various mystical, hedonistic, and magico-religious beliefs. Bayezid eventually built a city called 'Hashtnagar' and gave himself the title 'Sage of Illumination.' Although the history of the cult is somewhat nebulous, it is known that the cult was widespread, influential, and troublesome to the authorities in Kabul. Daraul states that the Afghani segment of the cult split into military and religious factions, and that the religious division survives to the present day.

Although its connections with Afghanistan are uncertain, a German branch of the society was founded on 1 May 1776 by Adam Weishaupt, a Jewish professor at the Bavarian University of Ingolstadt. The original name of the Illuminati was 'the Order of Perfectibilists,' and its first meeting was attended by only five people. The size and influence of the Illuminati spread quickly, however, with lodges founded in Italy, Hungary, France, and Switzerland. There was extensive infiltration of Masonic lodges by Illuminati.

The degree of involvement of the Illuminati in the French Revolution of 1789–99 is uncertain, but could be considerable since prominent members of the Revolution, including the Comte de Mirabeau, were Illuminati. The overall philosophy of the Illuminati was one of social reform and creation of a world government. Howard (1989) suggests that the Illuminati, Masons, Rosicrucians, and Knights Templar are intertwined in history, and that these secret societies have had an influence on world events up to the present.

One of the key symbols of the Illuminati was the Egyptian pyramid with an eye above, which appears on the back of the American dollar bill. The idea of using this Illuminist–Masonic symbol was proposed to President Roosevelt by his Secretary of Agriculture, Henry Wallace. Wallace, who was intensely interested in the occult, was influenced by a Russian mystic named Nicholas Roerich.

Roerich, who apparently helped Stravinsky compose *The Rite of Spring*, travelled widely in Nepal and Tibet, where he studied with a group of occult adepts known as 'the Secret Chiefs,' 'the Hidden Masters,' or 'the Great White Brotherhood.' According to occult rumour, the Great White Brotherhood was the spiritual force behind the Freemasons, Knights Templar (a society founded in 1118, which was active for two hundred years), Rosicrucians, Sufis, the Hermetic Order of the Golden Dawn, and the Theosophical Society.

Clinicians working with ritual abuse survivors in North America today occasionally hear vague references to the Illuminati, who are said to be the élite group behind the Satanism. The rank of 'king' is mentioned by some Satanic ritual abuse survivors, and the pyramid and eye symbol, or the eye alone, often appears in their drawings. The Illuminist–Masonic–Rosicrucian tradition is intertwined with the history of Western civilization, but we have no conclusive knowledge about the political influence of this tradition today. Patients reporting involvement in Satanic ritual abuse cults appear to draw some of their imagery from the Illuminist–Masonic tradition, and information about much of this symbolism is readily available in bookstores and libraries.

The Thule Society

The Thule Society was established at the end of the First World War by Baron Rudolf von Sebottendorf. In 1918, it had more than 250 members in Munich, and a further 1,500 throughout the Bavarian countryside. Von Sebottendorf was initiated into a Masonic lodge in 1901, but created his own society after the war because of pressure on the Masons by the Communist Party. The German Workers' Party was founded by the Thule Society in 1919; Hitler was recruited to the party, became its leader, and changed its name to the National Socialist Party in 1920. A leading Thulist named Dr Frederick Kohn provided Hitler with the final design for the Nazi flag, and many leading members of the Third Reich belonged to the Thule Society. Thulist philosophy was one of racial superiority, world domination, and anti-Semitism, and the society engaged in secret rituals of an unknown nature.

According to Sklar (1977), von Sebottendorf published a book entitled *Bevor Hitler Kam* (Before Hitler Came) in 1933, with a second edition in 1934. The Nazis confiscated both editions and were likely responsible for von Sebottendorf's murder: Hitler's propaganda machine required a different account of the Führer's political origins than that put forward in the banned book. However, Howard (1989) states that von Sebottendorf committed suicide in 1945 when he heard of Germany's defeat, so the time and cause of the death of the Thule Society's founder are uncertain. Rather than being original, the Nazi doctrines of racial superiority, Aryan destiny, and the malevolence of the Jews were well established and widely adhered to before Hitler rose to power.

As did the Nazis, von Sebottendorf hated the Freemasons for two reasons: he thought that they had lost the original Aryan wisdom and that they were run by the Jews. Nazi propaganda was vehemently anti-Masonic as well as anti-Semitic. The structure of the Thule Society, like that of many other cults, was derived from Masonry, so there may also have been an element of envy in Nazi hatred of the Masons.

Howard (1989), Sklar (1977), and Ravenscroft (1973) provide the history of Nazi interest in the occult, which, according to them, was a major driving force behind the Third Reich. Howard states that this material was suppressed at the Nuremberg trials for fear that the Nazis would be found not guilty by reason of insanity. Sklar says it is rumoured that the inner circle of the Thulists actively practised Satanism, while Ravenscroft states it as a fact.

According to Ravenscroft, Hitler was intensely interested in the Spear of Longinus, which had been passed down through a succession of European rulers, and was thought to be the spear that pierced Christ's side. Hitler studied the spear intensively while living in Vienna before the First World War, and frequently went to view it at the museum where it was housed. The spear was entertwined with the legend of the Holy Grail and symbolized the ultimate Aryan power to Hitler, who believed that the man who possessed it could rule the world. When Hitler had the spear transported to Germany from Austria during the Second World War, many of those who attended the first viewing were former members of the Thule Society.

It appears that, besides their interest in Teutonic mythology, astrology, and the paranormal, the leading Nazis may have been involved in secret-society rituals. If this was so, then a destructive secret society has had an enormous influence on the twentieth century. Given the rise of destructive neo-Nazism in unified Germany today, it would be prudent

not to forget the role of the occult in the Third Reich, since such denial might foster emergence of a Fourth Reich, also driven in part by mystical Teutonic racial supremacy.

The Ordo Templii Orientalis

The Ordo Templii Orientalis (OTO), as it is called, was established around the turn of the century by Theodor Reuss, a German newspaperman who worked as a spy for the Kaiser (Raschke, 1990). Reuss was a student of Tantric yoga, a form of sexual magic whose origins stretch back into antiquity. In 1912, leadership of the OTO passed to Aleister Crowley, an Englishman born in 1875. In 1898, Crowley had joined a secret society called 'the Hermetic Order of the Golden Dawn,' which counted William Butler Yeats among its members. The Golden Dawn conducted séances, described in some of Yeats's poetry, and would today be regarded as a trance-channelling and astral-projection cult. However, the Golden Dawn appears not to have been deviant enough for Crowley, and he was expelled from it because of his practices.

Crowley established a headquarters called 'the Abbey of Thelema' in Cefalù, Sicily, at the end of the First World War, where he held orgies which may have involved blood rituals and human sacrifice. He called his rituals a 'Gnostic Mass,' and regarded himself as the Beast of Revelations. At age twenty-eight, while in Cairo, Crowley had a vision of a guardian spirit named Aiwaz: the entity identified himself as a representative of the Great White Brotherhood and instructed Crowley in a new world order based on occultism. Crowley was unsuccessful in establishing a new world order, however; he became addicted to cocaine and died in poverty in 1947. Crowley and the OTO are referred to by contemporary dabblers in Satanism, and some survivors have memories of being abused at Satanic OTO ceremonies into the 1960s.

Another facet of Crowley's career involved psychic opposition to the Nazis during the Second World War. The OTO was one of several secret societies banned by the Nazis in 1937, others being Theosophy, the Hermetic Order of the Golden Dawn, and the Order of New Templars. Crowley was also peripherally involved in the British intelligence plan to lure Rudolf Hess to Britain, and at one point it was proposed by British Naval Intelligence personnel that Crowley interview Hess about Nazi interest in the occult.

The British hired a Swiss astrologer to infiltrate the occult circles in Germany frequented by Hess, which was done successfully. Hess was told

that 10 May 1941 was an astrologically significant date, and that the Duke of Hamilton wanted to meet Hess on that date, leading to the German occultist's parachuting into Great Britain. The original plan had been to use occultist contacts of Crowley's, but this was abandoned because Crowley was known to the Nazis, having done spy work in pre-war Berlin for M.I.6, the Espionage Department of British Military Intelligence.

It is noteworthy that a known Satanist was employed by the British intelligence service to spy on the Nazis and was a candidate for interviewing Rudolf Hess. Crowley's life illustrates how the themes of Satanism, secret societies, the Great White Brotherhood, and the Illuminati are intertwined. The OTO is a verified Satanic secret society of recent origin and may still be active in North America.

Cannibalistic Cults throughout History

As a schoolboy, I was aware that the Aztecs practised human sacrifice, and it is common knowledge that ritual removal of organs from living victims has been practised throughout human history. In his book *Cannibalism: Human Aggression and Cultural Form* (1974), Eli Sagan describes the documented existence of cannibalism on all continents and among all racial groups. Writing from a psychoanalytical perspective, Sagan argues persuasively that cannibalism is characteristic of a primitive phase of cultural development, and that isolated acts of cannibalism in advanced societies are rare, but have occurred during periods of starvation or episodes of psychological regression.

Sagan's viewpoint on the epidemiology of cannibalism and human sacrifice in modern societies is the same as Richard Noll's. Noll argues, in his book *Vampires, Werewolves, and Demons: Twentieth Century Reports in the Psychiatric Literature* (1992), that the drinking of human blood and demon possession are rare, but still seen occasionally in modern societies. None the less, these two authors are in agreement that human sacrifice, blood drinking, and deviant cults of the type described by Satanic ritual abuse survivors are virtually non-existent in modern societies.

The memories of Satanic ritual abuse survivors, if they are even partially real, pose a major challenge to our usual beliefs about human history and the cultural evolution of our race. I have met dozens of people who claim to have participated in ritual cannibalism, drinking of human blood, and human and animal sacrifice, and who believe themselves to be demon-possessed. I have spoken directly with numerous alter personalities identifying themselves as Satan, in addition to many other

entities claiming to be servants of Satan. Demon possession is far from rare in our society; in fact, about 2 per cent of adults in the general population in North America report having had a possession experience (Ross and Joshi, 1992).

Since demon possession, understood as a form of dissociative disorder, is still relatively common in our culture, other phenomena thought to exist only in technologically primitive cultures may persist into the modern world, including cannibalism and ritual human sacrifice. Sagan (1974, p. 52) describes eight different types of cannibalism and human sacrifice, which I list in point form to emphasize that these practices are complex and heterogeneous:

1 Funeral customs and rites for the dead
2 Religious ceremonies to enhance the general welfare
3 Sacrifice to avert calamity
4 Sacrifice on great occasions
5 Sacrifice in connection with kingship
6 Sacrifice to aid fertility
7 Sacrifice of a scapegoat
8 Sacrifice to ensure success in warfare

Sagan leaves out other primary motivations of human sacrifice that I infer from the accounts of Satanic ritual abuse survivors:

9 Sacrifice to acquire spiritual power
10 Sacrifice to create dissociation in observers and participants, and acquire control over them
11 Sacrifice to appease a deity (Satan)
12 Sacrifice driven by calendrical and numerological beliefs
13 Sacrifice to augment the channelling of spiritual energy
14 Sacrifice to insert entities into participants
15 Curiosity
16 Sexual sadism

This is likely only a partial list of the primary motivations for human sacrifice. The fact that, based solely on my clinical experience, I can double the list of motives for human sacrifice drawn up by an authoritative scholar illustrates the fact that Satanic ritual abuse survivors provide a rich fund of cultural and psychological material for study – even if none of their memories is real.

Sagan's thesis is that cannibalism has disappeared from modern society primarily through *sublimation*, and he illustrates this point with detailed analyses of various cultures, including the transformation of cannibalism into potlatch ceremonies among the Kwakiutl of the Pacific Northwest. Even if none of the memories of the thousands of Satanic ritual abuse survivors currently in therapy in North America is real, they prove that primitive fantasies of murder, cannibalism, demon possession, and blood-drinking have been repressed rather than sublimated in our culture, and that a permissive myth readily draws them to the surface. If cannibalistic fantasies are so close to the surface, wouldn't one *expect* that they are being acted out, to some degree, in the modern world?

Let me clarify Sagan's distinction between *sublimation* and *repression* for those readers without psychoanalytical training. Sublimation is a healthy, normal process of civilization in which primary drives and urges are culturally transformed into something more human, complex, and meaningful, a cultural reality that did not exist during the previous stage of historical evolution. An example is the difference between 'eating' and 'dining': dining has many meanings, purposes, and elements that are not present in the eating behaviour of animals. The elaborate and codified interaction of waiter and patron, for instance, does not occur in the animal world, and cannot be explained purely in terms of survival and the acquisition of nutrients, since those needs can be met equally well at a fast-food restaurant. Once a drive is sublimated, it does not revert back to a primitive or destructive form, since it is something new and culturally higher.

Repression, on the other hand, involves no cultural transformation or evolution. Repression is an unconscious defence mechanism, of which the conscious equivalent is 'suppression.' In suppression, which we all do, memories, feelings, and urges are deliberately pushed out of awareness to be forgotten or considered later. Repression is the unconscious burying and sealing over of drives and urges. The chief problem with repression is a psychological phenomenon called 'the return of the repressed,' in which previously repressed material returns to consciousness in distorted and destructive form and then drives deviant behaviour.

According to the conventional view, cannibalism has been almost entirely sublimated in modern society, but Satanic ritual abuse survivors tell us that this is not so: urges to commit ritual rape, murder, and cannibalism have been unsuccessfully repressed and are now returning as

memories of participation in Satanic rituals. From a purely psychological point of view, it does not matter whether the Satanic impulses are actually being acted out on any scale or whether they are expressed primarily as pseudo-memories: the important point is that the repression barrier is breaking down on a wide scale. The degree of actual acting-out based on this return of the repressed in the late twentieth century is a sociological and law-enforcement problem, as I emphasized in the Preface.

One of the lessons we can learn from Satanic ritual abuse survivors is that the balance of sublimation and repression in our society concerning cannibalism and human sacrifice is shifted more towards repression than we had thought, and involves less healthy sublimation than we had thought.

Conclusions

The purpose of this chapter has been to review briefly some of the documented destructive secret societies throughout history. I have focused on groups that are intertwined with one another, and possibly connected to Satanism or other forms of ritual abuse. An immense effort of scholarship would be required to explore this theme fully.

Those who argue that there are no historical precedents for widespread Satanic ritual abuse and human sacrifice are mistaken: there have been numerous destructive secret societies throughout history, cannibalism is a known human behaviour, and the Catholic Inquisition (see chapter 3) and the Third Reich provide two examples of extensive, systematic human sacrifice in modern history.

Since there is so much historical precedent for the atrocities being remembered by Satanic ritual abuse survivors in the 1990s, a key issue is whether it is logistically possible for such activities to be widespread but lacking in objective documentation. This is a law-enforcement, not a clinical problem. Since no one knows the actual extent of criminal Satanism in North America today, clinicians must proceed with their therapeutic work in the absence of definitive information. Knowledge of the documented history of secret societies, even at the preliminary level I have provided in this chapter, should temper extreme skepticism and allow therapists to consider empathically the possibility that client reports of Satanism are, at times and to some extent, based on historical reality.

2

The Psychology and History of Satan

In order to treat Satanic ritual abuse survivors effectively, it is essential to understand the psychology and history of Satan. Since Satan is a historically dynamic and evolving figure whose characteristics are still in flux, we should not be locked into twentieth-century concepts in our efforts to help patients with Satanic ritual abuse memories. In this chapter I rely on four books by Jeffrey Burton Russell: *The Devil: Perceptions of Evil from Antiquity to Primitive Christianity* (1977); *Satan: The Early Christian Tradition* (1981); *Lucifer: The Devil in the Middle Ages* (1984); and *Mephistopheles: The Devil in the Modern World* (1986), and on *Satanism and Witchcraft* (1975 [1939]) by Jules Michelet. The purpose of the chapter is to establish a psychohistorical context for the later clinical chapters and to point out that the psychology of Satan has been a fundamental feature of our culture for many centuries.

In order to clarify the philosophical foundations of this chapter, let me state my underlying assumptions about Satan at the outset. I don't believe that Satan existed in the universe before the evolution of the human cerebral cortex. However, I do believe that Satan exists as a psychological reality in the same sense that alter personalities exist in people with MPD. I believe that Satan, thought of as a dissociated element of the psyche, has power, can take possession of human beings, can influence their actions independently of the will and consciousness of the executive self, and can have a profound impact on human affairs. I believe in the existence of evil as a human psychological principle but, to reiterate, I do not believe in evil as a first principle in the universe. I think of Satan as much more than a mere *concept*, *superstition*, or *symbol*: Satan is a living entity whose presence can be felt by a possessed person, and he can be directly observed by others when he takes executive control.

It seems reasonable to assume that possession by Christian demons never occurs among people who have not heard of Jesus or Satan, since Satan and demons do not exist as dissociated centres of psychological action in the minds of members of non-Judaeo-Christian cultures. In other cultures, the gods, demons, ancestor spirits, tutelary spirits, and other entities who possess human beings have other identities and are derived from other mythologies.

Satan can literally exist as a dissociated, thinking, independent entity in the human psyche; he can plot against the executive self of an individual; and he can function as the leader of a host of dissociated fragments and ego states. I have worked psychotherapeutically with infernal parliaments that are similar in structure and function to the one depicted in Milton's *Paradise Lost*. I have had direct conversations with a considerable number of alter personalities who believed themselves to be demons, and/or Satan himself, and all have turned out to be dissociated components of my patients' minds.

The history of Satan is the history of a profound dissociation in the Western mind: part of the Western psyche was split off, disavowed, and projected out into the universe as a principle of evil. Because this occurred at a cultural level, and was codified, reinforced, and entrenched over several thousand years, the personified principle of evil in the human psyche is experienced as *not self* in the same way that alter personalities are experienced as being literally other people by the person with MPD. Our culture tells us that we are not Satan, and that Satan is not us, because of a deep disidentification with a disowned aspect of our psyche.

Nietzsche described this fundamental dissociation as the division between the Dionysian and the Apollonian in his treatise *The Birth of Tragedy* (1972). Nietzsche understood that the badness of Satan is not inherent in the nature of the disavowed portion of the psyche. The evilness of Satan is an artefact of the hostile distortions of the cerebral cortex which feared, disowned, and suppressed an earlier, more ancient portion of the psyche, then called it evil.

Milton presents the same analysis in dramatic form in *Paradise Lost*, despite his inserting conventional Christian editorial commentary in his text. In *Paradise Lost*, the dramatic reality is that God is an arbitrary tyrant with borderline personality disorder, while Satan is an outraged victim who has been cast out of heaven on a whim and subsequently rebels in futile protest. The Jesus of *Paradise Lost* is a corporate junior executive who rushes around the universe, covering for God, trying to

restrain God's acting-out, and manipulating God's narcissism. The psychodynamic reality of Satan in Western civilization has been disavowed, much like the dramatic reality of Satan in *Paradise Lost*.

In this chapter, I trace the history of this psychic dissociation, and the changing visual and characterological portrait of Satan. An adequate account of the history of Satan from the point of view of my theory would require a full book, so I present only an outline. The key point of this chapter is that treatment of Satanic ritual abuse survivors must be based on an understanding of the psychology of demon possession and demonic alter personalities, combined with an understanding of the history of Satan.

The Mythological Beginnings

In the beginning of time, there was no Satan because men had not yet imagined him. God had not yet fissioned into a good and an evil principle, an event which was to become the fundamental dissociation of Western culture. In the primeval dream time before the dissociation, before the differentiation of God and Satan, there was no dualism; rather, the universe was one organism, of which man and his mind were a part. There is no evil among the animals – evil is a product of evolution. When children die in a hurricane, that is not evil, nor is it evil when a wolf devours a rabbit, or a rabbit devours a blade of grass. Evil requires the executive planning functions of the human cerebral cortex.

Prior to Zarathustra, the Iranian prophet who lived about 600 B.C., the religions of the world were animistic and polytheistic. Zarathustra created a religious system based on dualism and monism, which in turn produced a problem theologians have never been able to solve: if God is one and good, why is there evil, and why would a good God create Satan? To prevent God from being contaminated by the evil nature of Satan, it is necessary to have some degree of separateness of Satan from God, but since God is everywhere and everything, he must be Satan as well, and he must be the Creator of Satan; therefore, God himself must be evil or have an evil part-nature. To escape this conclusion, one must assume that Satan's evil nature is part of a divine plan incomprehensible to man. The whole problem is an artefact of the original dissociation, which was a psychological event driven by the need of the human cerebral cortex to disavow its own evil intentions in the world. The problem, defined theologically, has had no solution.

Theological attempts at solving the problem of why evil was created by a good God have led to an endless round of ambivalent oscillations, corrections, and countercorrections, with increasingly obscure modifications of theory required to deal with the problems that attend each attempt at solution.

Dualism exists on a spectrum, with Zoroastrianism at one end: in Zarathustra's universe, the principles of good and evil are fully dual and independently created, and do not share in each other's nature. In the mid-point of the spectrum, which is contemporary non-fundamentalist Christianity, the dualism is more covert – the problem is fudged over, and monism prevails, with God being the overall ruler of the universe, and Satan a subservient subprinciple. At the other end of the spectrum is absolute monism, with no separate principle of evil in the universe. The difference between absolute monism and the primordial dream time is that monism is intellectual, and the monist God is a dissociated, benign cognitive principle running the machinery of the universe, while, in the dream time, God is immanent in the universe and directly palpable.

Absolute monism is a theological definition of the dissociation of the executive functions of the psyche from the rest of the mind and body, but without projection of an evil principle outside the executive self (Ross, 1991a). Dualism, in turn, is a form of monism involving an additional mechanism of projection: the bad self has been cast out of heaven and named Satan. Our cultural ambivalence about the nature of this formerly good angel is evident in his name, 'Lucifer,' and the linkage of that name to dawn and the morning star, which are positive symbols.

The dualism of Iran differed from that of the Greeks in one essential aspect: for the Greeks, the principle of good was associated with spirit, while evil was associated with matter. These linkages did not exist for the Iranians. In any form, however, dualism fragments the universe into pieces in order to retain God's goodness by separating off the principle of evil, a strategy which inevitably reduces God's power, despite his being defined as omnipotent. A dualist theology fosters division within the psyche, projection, repression, and blaming, since the projected bad self becomes the Enemy.

The creation of a dissociated Evil Enemy inevitably leads to a cosmic war for domination, which, in Mazdaist (Zoroastrian) theology, occurred in three-thousand-year cycles, with eventual destruction of the evil Ahriman by the good god Ormazd. Mazdaism was a derivative of Zarathustra's doctrine of the existence of Ahura Mazdãh, the god of goodness

and light, and Angra Mainyu, the lord of evil and darkness. Another derivative fragment of Zoroastrianism was the Zervanite heretics, who represented another permutation of the theology. These spin-offs from Zarathustra's original doctrine illustrate how an initial dissociation generates countless further subdissociations, as schools adherent to one or another attempted solution of the dualist problem become sociologically entrenched as separate religious factions.

The important psychological point about these solutions to the cosmic war between good and evil is that none resulted in reintegration of the psyche or the universe, and all involved repression and defeat of the evil principle. Since the evil principle never actually dies psychologically, history becomes an endless re-enactment of the return of the repressed, with Satan increasingly angry, rejected, self-righteous, and vindictive after each subjugation.

The linkage of the evil principle to matter eventually led to a model of the universe in which Hell was at the centre of the earth, and God at the outer perimeter, with the angels just below God. In this model, the universe consisted of concentric spheres, with the moon revolving around the earth at a lower level than the sun. Hell, matter, and evil were geographically as far away from God, goodness, and spirit as possible: of course, since God was also everywhere, the dualist problem persisted. The psychological ramifications were important, however, for now the human body, being composed of matter, became inherently coarse and evil in nature, if not frankly demonic.

The identification of the demonic with the underworld, sexuality, and the human body was completed because of the influence of Greek mythology. Numerous myths, such as that of Persephone, associated fertility, rejuvenation, beauty, and sexuality with the underworld, and this linkage was reinforced by a welter of pagan fertility cults, all of which were defined as evil by Christianity. Christianity located the brain in Heaven and the clitoris in Hell. One of the classical mythical images was that of the wild, sexual Dionysian frenzies of Greek women who held orgies and sacrifices in the hills: this was the cultural precursor of the Witches' Sabbath.

The dissociation of God and Satan, and the hostility towards the body resulting from the identification of evil with matter, became entrenched in Christian doctrine. The early Christians deliberately placed Easter on the calendar so that it supplanted spring fertility rites and myths such as that of the Fisher King, while Christmas supplanted winter-solstice ceremonies. This was a deliberate evangelical and political strategy. Rather than

representing an advance in civilization, however, Christianity made the mistake of suppressing the evil principle, which it feared. This is the same error that cannibalistic societies make when they suppress rather than sublimate the desire to eat human flesh, as described in chapter 1.

Christianity sought to replace the earlier pagan fertility cults through sublimation but failed. The core myth of Christianity is sacrifice of the evil principle of matter on the cross, with triumph of the principle of good. The conception of Jesus had to be immaculate because of the fundamental dissociation of mind and body, good and evil, matter and spirit. The divine principle of light at the outer edge of the universe could not participate in the carnal, corporeal fact of human biological reproduction because that would result in contamination by evil. One implication of this myth is that Joseph is a mere accessory, required only to provide Mary an income and support, and that only women participate in the divine act of creation with God.

Christianity is supposed to represent a sublimation of prior human sacrifice cults, and the ritual cannibalism of Christianity, called 'communion,' is supposed to be purely spiritual in nature. This is not true psychologically, because what really happened was political suppression of earlier religions, and psychological repression followed by symbolic re-enactment of earlier ceremonies. At communion, Christians eat the body and drink the blood of Christ, which is paradoxical because his body was sacrificed on the cross while being equated with the principle of evil. If a group of New Guinea highlanders practised a religion in which their god, embodied in an actual human being, was nailed to a tree, killed, then ritually cannibalized, they would be viewed with horror by Christians. Claims that the New Guinea god died willingly to bring fertility to the highlanders would not impress Christian evangelists working with such people.

The paradox and the psychopathology of the myth of Jesus is its mixture of envy, hatred, idealization, and projection. The evil principle became the flesh, and the flesh was sacrificed, then idealized and cannibalized, thereby renewing the spirit. God was not hurt by his sacrifice because the conception of Jesus was immaculate, and it wasn't really God in the sacrificed human body, it was his son. Therefore, the devout were not really angry at God, and did not kill him. The cosmology of the religion is committed to hatred, fear, suppression, and eventual destruction of the evil principle, which is linked to the physical body, so in sacrificing the body of Jesus, the Christians were really killing Satan. As an additional layer of defence, the wish to kill God was projected out onto

the Romans, who were representatives of Caesar – a puppet of Satan. God's body being dead, the Christians want to eat it in order to have the evil principle inside them: this impulse is disavowed by claiming that it is God's *spiritual* body that is eaten at communion.

The sacrificed goat of prior mythology was transmuted into the Blood of the Lamb, and Christians are to be washed in the blood of this sacrificial animal. All of this may possibly look like sublimation, symbolism, and an advance in civilization, until we examine the breakdown of the repression, which is the Catholic Inquisition. The burning of witches for three hundred years in Europe was not an *anomaly* in the history of Christianity; rather, it was an inevitable consequence of, and evidence of, the repressive nature of the religion. If the psychology of the religion was truly based on sublimation, there could never have been a Catholic Inquisition, and sexual abuse of children by clergy would not occur in the twentieth century.

Do not conclude from what I have said here that I am anti-Christian. Observing that there is something fundamentally wrong with the psychology of a religion which burnt millions of witches at the stake over a period of three hundred years does not imply that the religion as such is wrong. It simply means that the myth, the theology, and the social power of the religion were harnessed by men driven by dissociative psychopathology. These men created a distortion and perversion of Christianity, and my analysis attacks that distortion and not true, sublimation-based Christianity.

The mythological beginnings of Satan are in a dualist dissociation of mind and body, good and evil, matter and spirit. Evil impulses originating in the human mind and body were disavowed, projected out of the psyche, and eventually named 'Satan.' Attempts to suppress the evil principle were unsuccessful because the pagan, sensual, animistic reality of human fertility could be destroyed only if the human race was biologically destroyed. The Good Fathers envied, feared, hated, and lusted after the evil principle, in the form of women, boys, and girls, and they acted out this conflict in many different forms over the centuries. This psychology is still being acted out in the world today, including in the current debate about false memories and Satanic ritual abuse, as I discuss in the final section of this book.

The Watcher Angels

The myth of the Watcher Angels appears in the Apocalyptic book of

Enoch, which elaborates on cursory references to the fallen angels in Genesis. This myth is directly related to the psychology and history of Satan, contemporary Satanic ritual abuse, and the internal structure of the personality systems of people with multiple personality disorder. The leader of the Watcher Angels was Semyaza, while the Devil had various names, including 'Belial,' 'Mastema,' 'Azazel,' 'Satanail,' 'Sammael,' 'Semyaza,' and 'Satan.' There was confusion about the precise relationship between the leader of the Watchers and the Devil.

Semyaza encouraged the Watcher Angels to make a formal agreement to descend to earth and impregnate the daughters of men. The Watchers subsequently did descend to earth, took wives, and taught men the art of weaponry, which makes them very similar to the Titans of Greek mythology. The children born of the union of the Watchers and human women were destructive giants who turned upon man and practised human cannibalism.

In the next step in the myth, men appealed to God for protection from the Watcher Angels, so God sent the archangels Uriel, Raphael, Gabriel, and Michael to earth, and they vanquished the Watcher Angels in battle. The ghosts of the Watchers remained on earth, however, where they persecuted man into the future. The Watcher Angels were highly lustful and carnal in nature, and their giant offspring are thematically similar to the Frost Giants of Norse mythology. The Watcher Angels are best understood as a projection of the carnal desires of celibate holy men.

One peculiarity of the myth of the Watchers is that, though fallen, they descended to earth of their own accord and were not cast out by God. As well, in one account they descended to earth before the fall of Eve in the Garden of Eden: in Jubilees, they came to earth in the days of Jared, five hundred years after the Creation. The Testament of Reuben added another facet to the evolving myth – namely, that the Watchers were actively seduced by human women, who wore make-up to attract them. Additionally, since the Watchers were spiritual in nature, they could not participate in biological reproduction; therefore, the Watchers came to women while they were having intercourse with men. The women conceived alien beings because of their lust for the Watchers, which is clearly a precursor of the intercourse of witches with incubi.

The Book of the Secrets of Enoch adds another element to the myth – namely, that the leader of the Watchers became power-hungry and decided to place his throne on high in an attempt to become equal to God. This made God angry and resulted in his banishing the Watchers

from heaven. The lust and political ambition of the Watchers became intertwined, which, if we remember the theme of projection, means that this intertwining was occurring in the minds of the writers of the books of the Apocalypse.

We never hear about the Watcher Angels in contemporary Christianity because they created a chronological problem as the medieval myths of Satan, the temptation of Eve, and the fall of Man were crystallizing. Originally there were a number of versions of when Satan fell: (1) at the beginning of the world, before the fall of Adam; (2) from envy of Adam; (3) with the Watchers, about the time of Noah; (4) at the advent of Christ; (5) at the passion of Christ; (6) at the second coming of Christ; and (7) a thousand years after the second coming.

Over time, the Watchers were assimilated with Satan, lumped together as the fallen angels, and given a minor role in the cosmology. This was handy because it glossed over the prior inconsistencies in the chronological history of Evil and helped solidify the orthodox myth of Satan. The relationship between the myth of the Watchers and contemporary Satanic ritual abuse has several dimensions.

First, as pointed out by George Ganaway (1989b), there is a marked similarity between the memories of Satanic ritual abuse survivors and those of UFO abductees (Hopkins, 1981, 1987; Streiber, 1987, 1989). There are thousands of people in North America today who are recovering memories of being abducted into spacecraft by aliens, experimented on, and being used to create half-human, half-alien babies. This is the myth of the Watcher Angels in twentieth-century form.

Alien abductees enter therapy with periods of missing time and unexplained post-traumatic symptoms, just as Satanic ritual abuse survivors do. The abductees report having hypnotic amnesia barriers deliberately implanted by the aliens, while the cult survivors report being similarly programmed by Satanists. Survivors of Satanic ritual abuse also describe ritually enforced pregnancies, medical experimentation in laboratory-like settings, and deliberate removal of the foetuses before term, the difference being that, whereas Satanists use the foetuses for ceremonies, the aliens raise them as children.

The myth of the Watcher Angels has returned from behind the historical repression barrier and is active in our culture, on television, in movies, and in books. There are UFO cults with thousands of members, including one based in Long Beach, California, run by a woman to whom all four thousand members have turned over their lifetime assets. Members of this cult are allowed to possess only material objects that

can be contained in a valise of specified size. There is a reason for this restriction in material possessions: this is all the personal cargo space that will be available when the Mother Ship comes down to pick up the cult members.

Satanic ritual abuse survivors are also watched over by evil Watcher Angels, in the form of Satanists, who have impregnated them, and whom they both lust after and fear. The ritual abuse survivors have alter personalities who claim to report back to the cult, to be loyal to it, and to participate willingly in Satanic sexual orgies. The Watcher myth always undergoes a technological elaboration in the twentieth century: the Satanic cult uses sophisticated monitoring, surveillance, and bugging technology to keep track of the survivors, most of whose lives would be impoverished and empty if they were not the valued sexual property of the Watchers.

Although the content of Satanic ritual abuse memories is a reworking of cultural myths and psychological conflicts, this fact has no weight in trying to determine the current objective reality of Satanic ritual abuse. The widespread existence of such unconscious symbolism can lead to the prediction that the myth is likely being acted-out in the world to some extent, while simultaneously suggesting that the memories are really all mythical symbolism, without any accompanying sociological reality. The challenge to clinicians is to develop a treatment method which will be effective no matter what degree of historical reality the memories have.

The connection between the Watcher Angels and multiple personality disorder occurs in several ways. First, many survivors of Satanic ritual abuse have MPD. More important, both ritually and non-ritually abused MPD patients often have Watcher Angels in their personality systems. These are sometimes benign and cognitive in nature, in which case they are called 'Inner Self-Helpers,' while in other patients they may more closely resemble the Apocalyptic Watchers in character. MPD patients in cultures that lack Watcher mythology will not have this type of alter personality in their personality systems.

The Evolving Visual Image and Characteristics of Satan

Satan as we visualize him today did not exist prior to the last thousand years. Even his name was a long time in the choosing, with variations on the word 'Satan' competing for supremacy over entirely different names. The image of Satan has evolved and undergone several different trans-

mutations in the last millennium, while the underlying cultural dynamics and the acting-out of the myth have not changed.

I will pick up the history with a Bulgarian heresy started by a man named Bogomil in about A.D. 950. He reworked previous theological ideas taken from Gnosticism, Manicheism, and other sources, and established a sect which achieved a widespread following throughout the Byzantine Empire by the eleventh century, then went into decline, persisting in Macedonia into the fifteenth century.

In Bogomil's theology, the true God was highly spiritual in nature and was physically located in a position remote from the material universe. He had two sons, an older one named 'Satanael' and a younger one named 'Christ.' Satanael had superior rank to Christ in Heaven, and sat at God's right hand until he became dissatisfied with his subservient position, lusted after power, angered God, and was cast out of Heaven. Because of their respect for Satanael, and because he promised them freedom from tiresome liturgical duties imposed by God, one-third of the angels cast their lot with Satanael.

While wandering in the void, Satanael decided to make a second universe to mimic God's creation, so he created the universe in which we live. Satanael is thus equated with the Creator God of the Old Testament, providing further evidence of mythological confusion about the relationship between the Evil Enemy and the Good God. Satanael's next job was the creation of Adam, a task which posed serious technical difficulties. When he tried to stand Adam upright, Satanael noticed that life was trickling out of Adam's right foot and right forefinger, in the shape of a serpent. Realizing his technical limitations, Satanael turned to the Lord for help in creating man, and the Lord obliged because he saw an opportunity to eventually replace the one-third of his angels who had left Heaven by repopulating his Kingdom with the souls of dead men.

In one version of the myth, Adam lay lifeless on the ground for three hundred years while Satanael wandered the earth, stuffing himself with the flesh of unclean animals. He then returned to Adam, stopped up all his body orifices, and vomited into Adam's mouth, while tricking God into breathing life into Adam. The theological moral of this story is that the human body is the evil and disgusting creation of Satanael, and the spirit, the creation of God, is temporarily trapped in this vile container. Eve was created by a joint effort of God and Satanael, following which Satanael, in the form of a serpent, had intercourse with her, resulting in the conception of twins, Cain and his sister, Calomena. Abel was conceived from a biological union of Adam and Eve.

The Lord punished Satanael for his rape of Eve by depriving him of his divine form, taking away his power of creation, and giving him dominion over the material universe for seven ages. After 5,500 years, the Lord sent Jesus to earth to help man rise up out of imprisonment in the material cosmos, an essential part of God's plan to repopulate Heaven. Christ entered the Blessed Virgin Mary through her right ear and was born out of her right ear, in a very immaculate conception. In order to preserve an extreme dissociation of God and Satanael, spirit and matter, the Bogomils rejected communion, the building of churches, baptism, and the conventional priesthood. They held that demons lived in the Temple of Jerusalem, which was the centre of a Satanic cult promoted by Moses, and they practised an extreme asceticism by avoiding meat, marriage, and sex. This impulse, universalized and carried to its logical extreme, would result in the biological extinction of the human race, which, in turn, is a logical outcome of the psychodynamics of the Bogomil heresy. The Bogomil heresy is a permutation of the other myths of Satan and their underlying psychology.

An important feature of Bogomil demonology was that it included very little pictorial representation of the Devil. The origins of Satan are in a non-personified dissociated element of psyche; the process of personification took almost two thousand years, from the time of Zarathustra until its medieval crystallization. In fact there are no surviving visual representations of Satan dating from before the sixth century.

The connection between Satan and the Jews, which was finally acted out in full by the Nazis, began as early as the papacy of Gregory the Great, from A.D. 590 to 604. Gregory held that true followers of Christ constitute his mystical body, a doctrine intertwined with communion, and that followers of Evil consitute Lucifer's body and are identified as the Antichrist. Gregory stated that it was especially heretics and Jews who were representatives of the Antichrist. The Antichrist became increasingly anthropomorphized and eventually took on bodily form, while the relationship between Satan and the Antichrist became the topic of endless theological permutations.

Representations of the Devil in paintings did not become common until the ninth century and took various forms. The Devil appeared in a humanoid form appeared in the sixth century, and this representation dominated from the ninth through the eleventh centuries, but it was accompanied in parallel by a small imp-like form of the Devil. The monstrous, animal form of the Devil did not appear until the eleventh century, and it was preceded by various images related to satyrs, some with

clawed feet and a tail. Another form was a white-robed humanoid angel with feathered wings and shoulder-length hair. The Devil was usually naked and most often hairy, and his accompanying demons were imp-like, or took various hideous or animal forms.

The Devil's wings were feathered, like those of the angels, until the twelfth century, when they were transformed into bat wings, and simultaneously his sleek, black hair began to become more monstrous. The Devil's colour also evolved through a variety of shades to standard black, and did not become red until the later Middle Ages. The standard image of the monstrous, huge, bat-winged Satan with a forked tail did not crystallize until many hundreds of years of mythical evolution had been completed, and this image did not remain stable for long. The truly grotesque forms of Satan did not start to become dominant until the fourteenth century.

Further transformations of Satan were already under way in medieval stage plays of the twelfth and thirteenth centuries, in which Satan and the demons begin to evolve into comic figures: this became a major cultural strategy for dealing with popular fear of Satan over the next centuries. In some plays Satan began to be portrayed as a clever courtly lover whose seduction of Eve required the wiles of the best womanizer, and the demons began to be funny. Russell (1984) describes four different forms of humour concerning demons, one of which was a parody of human foibles and lusts. The audience was to laugh *at* the demons, not with them, since conventional demonology still ruled the stage, but a hint of dramatic empathy with the Devil had begun to creep in.

Gradually the demons became the butt of jokes, and the stage began to be populated by a variety of different buffoons and fools, in a line of development which led to Puck and Falstaff. Over the next centuries, several offshoots of Satan developed, all of which were strategies to reduce his fearsomeness and make him a secular figure. In one line of development, Satan became a scholar, a form which evolved into Faust. There is good evidence that Satan evolved into Santa Claus in another developmental line.

The Devil was associated with the North and reindeer, could wear red fur, went down chimneys in the guise of Black Jack or the Black Man, carried a large sack into which he put sinners, flew through the air, and was left food as an offering. One of his names was 'Old Nick,' derived from St Nicholas, who was associated with fertility cults, and thereby with fruits, nuts, and fruitcake – the origins of Christmas cake. The theme of eating Satan was made secular and transformed into the eating of Christmas

cake, while pagan beliefs about trees were incorporated into the myth of Santa Claus as the Christmas tree, under which the bounty of the Devil's harvest is placed. Christmas gifts are a representation of the things of Caesar, and are therefore material, inherently gross and evil in nature, and linked to the Devil, according to classical theology.

Christmas as celebrated in the late twentieth century embodies two dissociated tracks of mythology. On the one hand, there are the Christian celebrations of the birth of Christ, the immaculate conception, the anticipation of Easter, and the communion, all of which are repressive reenactments of earlier fertility and human sacrifice religions. On the other, there are the secular transformations of these themes into Santa Claus, who is Satan in disguised form distributing his bounty to the children of devout churchgoers. Christmas involves a subdivision of our culture into two parallel myths, both of which embody in disguised form the theme of the cannibalism of the sacrificed God.

In further development of the scholarly Devil, a Romantic transformation of Satan as a rebel against an unjust social order had evolved by the nineteenth century, with Satan taking the role of witty social critic and rake. This portrait of Satan, as I said earlier, was already present dramatically in Milton's *Paradise Lost*, written in the seventeenth century. Finally, by the twentieth century, the fear of Satan had been thoroughly transformed into children's stories and Hallowe'en tales about witches and goblins.

The second great secular myth of our culture, Hallowe'en, involves collecting Caesar's bounty in sacks and devouring it, in the form of Hallowe'en 'treats,' while goblins, witches, and ghouls roam the landscape in demonic revelry. The cry of 'trick or treat' is a culturally disguised memory of the trickery of the Infernal Serpent, a mythology which makes it psychologically acceptable to have sex with children, since they are demonic, serpentine seducers of adults, and exploit adults for gifts of candy.

In an inversion of these roles, in response to the cry 'Hallowe'en apples,' the adult serpent seduces the Eve-child into biting the candied apple. This mythology is acted out in court when a paedophile's lawyer argues that the child was the seducer, the legal problem being how to decide who is Eve and who is Satan in the drama, and whether Eve actually is culpable, as she was in the seduction of the Watcher Angels or in witches' intercourse with incubi.

These themes appear over and over in the psychotherapy of Satanic ritual abuse survivors, transformed in various ways.

The Current Image of Satan in Satanic Ritual Abuse Mythology

Satan is frequently mentioned by Satanic ritual abuse survivors, and alter personalities identifying themselves as Satan are encountered frequently in their therapies. I describe the alter personality, Satan, in more detail in later chapters. Here, I explore the theological conception and pictorial representation of Satan among contemporary Satanic ritual abuse survivors.

Since the Middle Ages, Satan has evolved in reverse, back towards a more abstract and less personified representation, similar to that of Zarathustra. Contemporary Satanists do not seem to bother themselves much with pictorial representations of Satan, and seem to think of him as a disembodied Evil force who can take various forms. He is the pure Antichrist, a palpably present principle of evil in the universe, whose power can be harnessed by Satanic rituals, thereby providing sexual ecstasy.

The Satanic rituals, whether they are fantasies or actual events, are the mirror opposite of repressive Christianity: the Christian devours the spiritual body of Christ, the Satanist eats his victim's heart; the Christian has an upright cross, the Satanist has an inverted one; the Christian is washed in the Blood of the Lamb, the Satanist in the Blood of the Goat; the Christian priest is celibate, the Satanist is a paedophile; the Christian reads the Bible, the Satanist defecates on it. The Satanist does literally what the Christian does in disguised form: the Christian drinks wine that represents the Blood of Christ, while the Satanist drinks actual blood; the Christian's God was nailed on the cross, the Satanist ties his victim to the altar; and so on.

The mirror-opposites also exist internally, because the Satanist with multiple personality disorder often has a host personality who is a fundamentalist Christian. In such people the repressed impulses are acted out symbolically in church and literally in the Satanic ritual, with the Good Father being amnesic for the activities of his Evil Twin. This is true whether the Satanic rituals are acted out in external reality or only in an internal landscape.

Although Satan is usually conceptualized by ritual abuse survivors as a non-pictorial principle of evil lurking in the background, and having power and influence over human events, the alter-personality Satan is usually drawn as a conventional Devil with horns, black clothing and a cape, a forked tail, and a leering or threatening facial expression. This image is a historical remnant of the medieval Satan.

Conclusions

The proper task of mental-health professionals is not to determine the degree to which the cultural psychopathology of Satan is being acted out in the world today: that is a problem for law enforcement. Our cultural task is to understand the *psychology* of what has been going on, which cannot be done through polarized, ideologically driven debates about the degree to which acting-out is actually occurring in the external world.

It is nevertheless impossible to deal with Satanic ritual abuse cases therapeutically without being caught up in the question of how much of it is real. How to deal with the problem of the reality of Satanic ritual abuse in therapy is a topic for later sections of this book. In summary here, I reiterate that informed discussion of the psychological meaning of the memories of Satanic ritual abuse survivors *must* occur in a historical context, and be accompanied by an understanding of the cultural psychodynamics of Satan. Too often, discussion occurs in a vacuum, and therefore is not real, though it is intensely polarized: this polarization of opinion about Satanism is yet another manifestation of the dissociation driving our culture and history.

3

The *Malleus Maleficarum* and the Catholic Inquisition

There have been two major examples of systematic human sacrifice in modern Western history, the Catholic Inquisition and the Third Reich. The Nazis sacrificed six million people on the basis of Aryan racial mysticism (Sklar, 1977; Ravenscroft, 1973), while estimates of the number of people liquidated by the Catholic Church over a three-hundred-year period from the mid-fifteenth to the late eighteenth century vary from several hundred thousand to nine million. The 'witches' were sacrificed to a religious–theological organization which had as its central myth the sacrifice and ritual cannibalism of its god, Jesus.

The Catholic Inquisition illustrates a number of themes essential to careful thinking about contemporary Satanic ritual abuse. The first and most important is that a hysterical, destructive reaction to Satanic ritual abuse *rumours* (Mulhern, 1991; 1994) can be far more dangerous and evil than any actual activities of practising Satanists. The potential for such a reaction is well developed in contemporary society, as represented by the statement of Pat Robertson quoted by *The Dallas Morning News* which is a part of the epigraph to this book. The far right of Christian fundamentalism, if unchecked, might not stop at book burning in their zeal to fight Satan, and might go at least as far as pervasive suppression of civil liberties.

The Inquisitors were, in fact, greater hysterics than the witches. This aspect of the Inquisition has its equivalent in contemporary society, in the rumour panics and hysterical reactions to Satanism that have been documented by sociologists (Richardson, Best, and Bromley, 1991). I describe the hysteria of the Inquisitors later in this chapter. In the final section of this book, I discuss how the relationship between the Inquisitors and the witches is being repeated in the twentieth century, not just

in the relationship between borderlines and psychiatrists but in the social dynamics of the False Memory Syndrome Foundation. Those who do not understand the history and psychology of Satan and the Catholic Inquisition are more likely to repeat it.

The Catholic Inquisition was driven by an elaborate, codified theological system which was the product of centuries of intellectual effort and was sanctioned by the supreme religious authority of the culture in which it occurred. The Inquisition was regarded as the work of God, carried out with God's full approval and direction, since it was established by Papal Bull. The Inquisition illustrates the fact that large-scale human sacrifice is usually driven by a theological system in a detailed, planned fashion, rather than occurring as random acts of violence.

The Inquisition was also driven by a mixture of adultery and political intrigue. The history of the Devils of Loudon, which I describe below, best illustrates this aspect of the Inquisition (Michelet, 1975/[1939]).

The majority of victims of the Inquisition were women, while the perpetrators were almost exclusively men. I believe that many of the witches must have been victims of childhood sexual abuse: their symptoms of demon possession and collaboration with Satan were probably indicators of childhood trauma. This history has been repeated in the twentieth century by both the Church and psychiatry, each of which has disavowed the traumatic origins of 'hysterical', dissociative and possession symptoms.

Consistently in a number of different studies, about 10 per cent of physicians, psychiatrists, psychologists, and social workers admit to having had sexual relations with their patients or clients. Likewise, pervasive institutionalized sexual abuse by clergy of all denominations, but particularly by Catholic priests, has come to light over the last decade. In this way, the history of the Devils of Loudon is repeated in the twentieth century, the major difference being that the ultimate abuse, burning, has been eliminated. This humanitarian advance has not helped those victims of sexual abuse by priests and psychiatrists who have committed suicide.

The rate of completed suicide in patients with borderline personality disorder is about 10 per cent: this figure was established by a research literature which almost completely ignored the traumatic origins of the disorder. Studies published since the late 1980s have consistently demonstrated that the majority of people with borderline personality disorder, though not all, report childhood physical and/or sexual abuse. An unanswered epidemiological question is whether the percentage of sex-

ual abuse victims who die by suicide in our society is significantly lower than the percentage who died by burning four hundred years ago.

My research in the general population found that borderline personality disorder affects about 3 per cent of adults in the city of Winnipeg (Ross, 1991): if 10 per cent of these individuals commit suicide, one can predict that as many as 0.3 per cent of adults in the general population will die as a result of borderline personality disorder/childhood trauma. Taking this statistical projection farther, if we assume there are 150 million adults in North America, then about 450,000 people currently alive could die as a result of childhood trauma/borderline personality disorder. How many of these suicides would not occur in the absence of further sexual victimization in adulthood by clergy and mental-health professionals, and in how many cases was a clergyman the primary childhood abuser? This rough, informal calculation is included, not because it is scientifically precise, but because it illustrates that the psychology of Satan, as acted-out in the sexual abuse and later completed suicides of women with borderline personality disorder, is a serious, large-scale public-health problem in the 1990s. The calculations are meant only to illustrate the order of magnitude of the problem, and do not represent a scientific estimate. I explain the connection between Satan and borderline personality disorder below.

The 10 per cent rate of suicide in borderlines has presumably been continuous since the diagnosis of borderline personality disorder first began to emerge in the late 1940s (Hoch and Polatin, 1949). Until the late 1980s, the roots of borderline personality in childhood trauma have been ignored and rarely even commented on by the psychiatric profession. However, the literature on how to 'treat' and 'manage' borderlines is immense. Psychiatry's record in dealing with the long-term consequences of childhood trauma in the twentieth century may not have been much better, in terms of morbidity and mortality, than that of the fifteenth-century church. What we see in both periods is pervasive institutionalized rationalizations for maintaining the status quo, combined with negative characterological attributions of blame directed at the victims of childhood trauma. The elimination of the ultimate abuse, burning, was a public-health measure that occurred before the advent of modern psychiatry; thus, psychiatry cannot take credit for the eradication of that form of abuse in the twentieth century.

In the twentieth century, psychiatry has developed a codified ideology for dealing with witches, who have been renamed 'hysterics' and 'borderlines.' The majority of individuals reporting involvement in Satanic

TABLE 1
Witches, Women, Borderlines, and Hysterics

1486 *Malleus Maleficarum*: 'Witch'	1851 Schopenhauer: 'Woman'	1987 *DSM-III-R*: 'Borderline'	'Histrionic'
credulous	childish	impulsive	dramatic
impressionable	silly	unstable in relationships	craving attention
slippery-tongued	short-sighted	given to angry outbursts	craving excitement
feeble-minded	lacking a sense of justice	exhibiting identity disturbance	overreactive
carnal	tending ineradicably to lying	exhibiting affective instability	given to angry outbursts
moody and angry	given to dissimulation	given to self-damaging acts	shallow, superficial
lacking a good memory	given to falsity	exhibiting chronic emptiness	egocentric
given to lying	treacherous	intolerant of being alone	vain
vain	ungrateful		dependent, helpless
adulterous	unaesthetic		manipulative, parasuicidal
deceiving			

ritual abuse cults in the 1990s meet *DSM-IV* diagnostic criteria for borderline personality disorder.

Witches, Women, Borderlines, and Hysterics

The definition of 'a witch' provided by chief Inquisitors Heinrich Kramer and James Sprenger in the *Malleus Maleficarum* (1971; originally published in 1486) is basically the same as that provided by the German philosopher Arthur Schopenhauer in his essay *On Women*, written in 1851, as shown in table 1. Twentieth-century psychiatry's definitions of borderline personality disorder and histrionic personality disorder, as described in *DSM-III-R* in 1987, cover the same ground, with minor variations and modifications. I refer to the *DSM-III-R* criteria, rather than those in *DSM-IV*, because the criteria of the former were in place at the time that Satanic ritual abuse became a public theme in North America. In any case, the criteria for borderline and histrionic personality disorders have undergone only minor changes in *DSM-IV*.

The definition of 'a witch' provided by the Catholic Inquisition was used judicially to determine a sentence of capital punishment. In the nineteenth century, with general advances in the humanitarian nature of society, the same definition was adopted to apply to women in general and was used to justify keeping women in a role of social subservience; despite radical changes wrought by feminism in the last few decades, the definition and its uses have persisted. The institutionalized negative characterological attributions of the predominantly male power élite have taken a *medicalized* form in the last decade of the twentieth century: now the victims of these attributions are 'bad borderlines' instead of 'witches.'

Whereas, in the fifteenth century, the negative characterization of witches was justified by Christianity and the authority of God, in the twentieth century, it is justified by science and the authority of medicine. The 'bad borderline' is frequently the target of sadistic countertransference within twentieth-century psychiatry. The treatment of borderlines by twentieth-century psychiatry is, on the whole, far more humane than the Inquisition's treatment of witches, and no one would choose the latter over the former. None the less, the basic psychodynamics of the ruling élite are the same in the twentieth century as they were in the fifteenth. Psychiatry's definition of the 'borderline' in the twentieth century is a symptom of ongoing cultural psychopathology, not a scientific advance. It represents not a change in the fundamental dynamics, but only a reduction in the degree of acting-out.

The fact that we call our witches 'borderlines' and hospitalize them rather than burn them, while institutionally ignoring the origins of many of their symptoms in childhood trauma, must be considered an advance, but a limited one in that it does not represent either a full understanding of or an adequate social response to the problem of child abuse.

The *Malleus Maleficarum*

The key to understanding the psychology of the Catholic Inquisition is the *Malleus Maleficarum*, which is basically the operations manual of the Inquisition. Inquisitors Kramer and Sprenger were appointed in a Papal Bull issued by Pope Innocent VIII in 1484 and wrote the *Malleus* as a guide for other Inquisitors. The *Malleus* is analogous to a twentieth-century text on how to diagnose and treat borderlines in that it contains a theoretical section, giving the intellectual rationale for the project, then

deals with diagnostic criteria and clinical tests for identifying witches, and follows up with a detailed discussion of disposition and treatment.

In the introduction to the 1928 edition, the Reverend Montague Summers, a leading Catholic theologian, has this to say: 'There can be no doubt that had this most excellent tribunal continued to enjoy its full prerogative and the full exercise of its salutary powers, the world at large would be in a far happier and far more orderly position today ... the witches were a vast political movement, an organized society which was antisocial and anarchical, a world-wide plot against civilization' (p. xviii).

Well into the twentieth century, leading Catholic theologians still regarded the Inquisition as a positive form of eugenics, designed to cleanse the gene pool, eradicating demonic contamination. The Nazis used psychiatrists to identify mental patients for sterilization and liquidation in the two decades following the appearance of the 1928 edition of the *Malleus Maleficarum*, and the same eugenics argument was used to justify these actions (Ross and Pam, 1995).

The Catholic Church, to my knowledge, has still not issued an official renunciation of the Inquisition. Not until 1992 did the Pope issue a statement that Galileo was not a heretic and had not committed blasphemy in saying that the earth revolves around the sun. Galileo had been kept under house arrest by the Catholic Church for many years for refusing to recant his belief in heliocentricity.

Within the dissociative-disorders field in 1995, many therapists and patients believe in the reality of a worldwide Satanic conspiracy, which they regard as a 'vast political movement.' These therapists believe completely and literally in the large-scale sacrifice of babies, sexual perversions, and political aspirations of the Satanists. They believe that their patients are actively monitored and accessed by the cult and programmed to harm therapists, to infiltrate hospitals and disrupt and gather intelligence on dissociative-disorders units, and to commit suicide if they do not remain loyal to the cult. Those who do not accept such beliefs as grounded in fact label them manifestations of 'hysteria.' Right-wing Christian fundamentalists in our society are eager to exploit these beliefs and fears; therefore, with the right combination of social forces, we have the potential for a second Inquisition.

Returning momentarily to Galileo, why was the Catholic Church so offended by his discovery that the earth revolves around the sun? Why would they not regard this discovery as a morally neutral scientific fact of no consequence to organized religion? Surely if God put the sun at the

centre of the solar system, that is simply a fact, and the prior belief, that the earth is at the centre, is simply a scientific error. Why was it necessary to place Galileo under house arrest? The answer can be found in the *Malleus Maleficarum*.

To digress slightly further, Galileo committed another heresy when he invented the telescope, looked through it at the moon, and observed mountains there. This observation violated a principle of the astronomical system devised by the Greek astronomer Ptolemy – namely, that all heavenly bodies and their motions are perfectly spherical. The Ptolemaic astronomical system had become interwoven with Catholic theology over the centuries, with the result that the foundation and structure of the Catholic *religious system* was inextricably intertwined with a particular model of the universe.

The Church employed a number of strategies to discredit Galileo. First, the theologians stated that no one should look through a telescope because it is demonic: demons hover around the telescope and distort the light entering it, creating a Satanic illusion of mountains on the moon. Consequently, anyone who looks through a telescope is wilfully exposing himself to demonic influence.

When this argument proved ineffective, a Catholic theologian named Father Clavius devised a back-up strategy: he stated that a transparent crystalline substance fills up the valleys on the moon, and that the doctrine of spherical heavenly bodies is thereby preserved. Galileo was put under house arrest as a police measure, both to set an example to others and to limit his heretical influence.

The doctrine that the earth was at the centre of the universe was part of a systematic medieval theology described in some detail in the *Malleus*. If one of the foundation stones of the system was removed, then the entire structure might collapse, including the political power of the Inquisitors, the burning of witches, and Catholic ideas about the nature of spirit. An example of the theology is the statement in the *Malleus* (1971 [1486], p. 107) that the stars are moved by spiritual essences, and by separate intelligences. According to this system, the universe comprised concentric layers, with the earth at the centre; the moon, the fixed stars, and other layers extended concentrically outward to the penultimate layer of angels and celestial intelligences; finally, one found God.

The structure of this universe was used to explain the relationship between matter and spirit, the nature of demons, and the ability of demons to interact with human beings. This universe was fully magical in its physics, and the Inquisitors believed literally and concretely in

many superstitions. For instance, the *Malleus* (p. 35) notes that, if a harlot plants an olive, it will not bear fruit, whereas, if a chaste woman plants an olive, it will. It also notes that God sends comets to foretell the deaths of kings (p. 34) and provides a detailed list of the magical powers of witches (p. 99).

In twentieth-century psychiatry, bad borderlines are said to be prone to polymorphous perversity, pan-anxiety, and pan-sexuality. In the fifteenth century, these were the characteristics of witches. The *Malleus* explains that 'adulterous drabs and whores are chiefly given to witchcraft' (p. 54) and that 'women are easily provoked to hatred' (p. 210). A lengthy list of the reasons why there are more female than male witches is provided (pp. 41–7), and the list overlaps with Schopenhauer's definition of women. In the *Malleus* we read that 'all witchcraft comes from carnal lust, which is in women insatiable' (p. 47).

One might suspect from these quotations that the Inquisitors were sexually insecure and suffered from castration anxiety. In fact, the *Malleus* is full of fears about men's penises being stolen by witches. The Inquisitors appear to be ambivalent about the literal physical reality of magical castration, stating that witches can 'truly and actually remove men's members,' but then adding that, unaided by demons, witches can produce only an illusion of castration (p. 87). Further, it is said that, 'when the devil by himself takes away a member, he does actually take it away, and it is actually restored when it has to be restored' (p. 122). And, finally, it is explained that a man in grace cannot actually lose his penis, but he can see other men's penises as missing (p. 120). This makes the implications of a fall from grace potentially quite serious.

In recounting a story of the magical castration of a man by a witch, the Inquisitors state: 'First, it must in no way be believed that such members are really torn away from the body, but that they are hidden by the devil through some prestidigitatory act' (p. 119). In this tale a young man observes with alarm that his penis is missing after a brief contact with a suspicious woman. He seeks the advice of a Father from the Dominican House of Spires, who looks in the man's pants and verifies that the genitals are, in fact, physically missing. The Father enquires about any suspicious women the youth might have seen, one is identified, the young man finds her and confronts her, and the penis is restored. A tally is offered of the justice meted out for such crimes (p. 111); Kramer and Sprenger record that the Inquisitor of Como burned forty-one incubus-loving witches in the year 1485.

The medieval belief in the incubus and the succubus is found in many

places in the *Malleus*. The incubus was a male-form demon that had intercourse with women; the succubus, a female-form demon that had intercourse with men. The fact that an incubus could impregnate a woman, who would then bear a demonic child, posed a metaphysical problem for the Catholic Church – namely, that, although demons were closer to matter in their composition than were angels, they were still non-corporeal and therefore should not be able to participate in the biology of human reproduction.

The problem is artfully solved in the *Malleus*, where it is explained that two mechanisms account for the phenomenon (p. 26). First, the same demon can transform itself into either an incubus or a succubus. Second, demons carry an incubation (an interesting piece of etymology) chamber of unknown nature inside themselves which can temporarily store semen and keep it viable. What happens is that a succubus has intercourse with a man, who ejaculates into the demonic incubator; the demon transforms into an incubus, quickly finds a suitable woman, has intercourse with her, and passes the ejaculate into the woman. This is the same sort of inventiveness that Father Clavius relied on in preserving the idea of the spherical nature of the moon.

The politics of this magical medieval universe are interesting. Gay-rights advocates in the 1990s will be alarmed, but perhaps not surprised, to know that, in the *Malleus*, the Inquisitors state that even devils will not commit the horror of sodomy: 'And the very great enormity of such as sin in this way is shown by the fact that all devils equally, of whatsoever order, abominate and think shame to commit such actions' (p. 30).

The magical machinations of witches, such as creating 'terrible hailstorms and tempests' (p. 14), are always evil, yet the same magico-religious powers exercised by Christians are expressions of the will of God. For instance, a story is recounted of a woman in Reichshofen, a wife of a nobleman, who became pregnant and engaged a midwife to care for her. The noblewoman was warned by the midwife, a 'most notorious witch,' not to go out of the castle, but did so, and as a result the baby died in her womb: 'And so it proved when her time came; for she gave birth, not to an entire abortion, but little by little to separate fragments of its head and feet and hands. And this great affliction was permitted by God to punish her husband, whose duty it was to bring witches to justice and avenge their injuries to the Creator' (p. 118).

In this story, God made use of a witch to carry out his will. The *Malleus* further recounts the story of a bishop who avoided a sexual-abuse charge because it was a devil imitating him who had been having inter-

course with the plaintiff (p. 134) and of a bishop getting a special dispensation from the Pope to use counter-witchcraft (p. 159). It was regarded as unacceptable for sailors to hire witches to provide favourable winds, yet it was fully acceptable to pray to Mary for a favourable military outcome in time of war.

Being a witch on trial was an experience in the logic of double binds. The Inquisitors were always right, given that God was on their side, and the witches were always wrong. We learn that, if witches confess, they are burned at the stake, while, if they commit suicide, this is the demon's attempt to avoid contrition or sacramental confession (p. 102). Witches are said to be glad to be burned in order to escape the Devil (p. 104), and if they do not confess they are tortured to death.

The Inquisitors apparently believed that they were doing God's work in a literal sense, because they describe the universe as God's personal torture chamber (p. 85), implying that their Inquisition was but a mirror of God's. They give a detailed theological rationale for why God permits the existence of evil in the universe, why he delights in the pain and suffering of the Devil, why he allows witches to do their work, and how he keeps things in check through the influence of the good angels. God has set up the diabolical machinery for the 'perfecting of the universe' (p. 73), but why God ever bothered with the universe to start with is not known. The God of the *Malleus* is a sado-masochistic sexual pervert.

Those concerned with the way that female rape victims are dealt with by the contemporary legal system will be interested to know that the Inquisitors state that the prior sexual behaviour of the accused is relevant in the trial of a witch (p. 213). Another gender issue of interest to feminists, implicit in the tale of the noblewoman who had a stillbirth, is the hostile description of witch midwives (p. 66) – a historical precursor of the attitude of some North American MDs to midwives in the 1990s.

Additionally, the standard approach of many twentieth-century physicians to the differential diagnosis of conversion disorders (disorders in which paralysis, blindess, anaesthesia, or other apparently physical problems are, in fact, psychological in nature) is prefigured in the explanation of how doctors differentiate natural illness from witchcraft (p. 87): in essence, they first rule out organic causes, then conclude that the disorder must be 'psychogenic,' or, more accurately, 'demonogenic.'

The recruitment techniques of witches are also described, and resemble those of contemporary destructive cults. Witches approach people who are made vulnerable by high levels of stress and access them by

exploiting their carnal desire or taking advantage of their sadness and poverty (p. 96).

The *Malleus* contains precursors of many of our current social practices and is built on the same psychodynamic foundation as the twentieth century's approach to borderline personality disorder. The Inquisitors lived in a magico-religious universe in which there was an intense, active battle between good and evil; in which their penises were in constant peril; and in which holy prayer, on the one hand, and demonic spells, on the other, could create hailstorms, miscarriages, and countless other changes in the course of history. God actively backed the social order of the day by sending comets to foretell the deaths of members of the power élite, but not those of commoners. The social context of the Witches' Sabbath and the Inquisition are well described by Michelet in his book *Satanism and Witchcraft* (1975 [1939]).

The Devils of Loudon

The story of the Devils of Loudon illustrates the sexual intrigue and power politics that were an element of the Inquisition, as well as the institutionalized sexual exploitation of nuns by the priesthood. A similar episode involving nuns at Louvier is also described by Michelet (1975 [1939]). The Ursulines of Loudon were an order of nuns who lived in strict isolation within the walls of their nunnery subsequent to reforms initiated at the Council of Trent. The nunneries of this period, the seventeenth century, were inaccessible to all men but one, the nuns' confessor. The confessor of the Ursulines in the early 1660s was Canon Mignon, who was related to the two principal magistrates in the district.

The status quo in Loudon was disturbed by the arrival of Urbain Grandier, a young Jesuit who came to carry out clerical duties. He was a charismatic preacher and philanderer who enthralled the town's women; made at least one woman, the daughter of the 'Procureur Royal,' pregnant; and became the love object of the erotic dreams of the young Ursuline nuns. Canon Mignon learned of this during the nuns' confessions, and became threatened and vengeful. He teamed up with various angry cuckolds and citizens of Loudon and began to plan the demise of Grandier.

The initial accusations against Grandier were that he was a 'debauchee, a sorcerer, a demon, a freethinker, who at church "bent one knee only and not two", a man who laughed at rules and regulations, and granted dispositions contrary to the Bishop's prerogatives' (Miche-

let, p. 197). The failure to bend both knees raised the ire of the Bishop of Poitiers, who ordered a trial by the Ecclesiastical Tribunal of Poitiers, resulting in the banishment of Grandier from Loudon. However, Grandier appealed to a civil tribunal, the case was reopened, and he was found innocent, an outcome achieved partly because the Archbishop of Bordeaux, a superior of the Bishop of Poitiers, was on Grandier's side.

A second strategy was then set in play to deal with Grandier, involving the Lady Superior of the Ursuline convent. A lay sister attending her developed convulsions and was possessed by the demon Leviathan, who spoke through her. This demon possession quickly spread to the other nuns, resulting in an epidemic of demon possession. According to Michelet, the nuns were trained to perform correctly in secret exorcisms conducted on the evenings before their demon possession was put on public display, and they were trained to speak in Latin as a demonstration of demonic xenoglossy.

The epidemic of possession was newsworthy and resulted in the Queen of France sending her almoner to investigate the situation. There was a great deal of intrigue, with figures on both sides exploiting their political and judicial connections. Not surprisingly, the demons speaking through the nuns accused Grandier of having intercourse with the nuns during the night. It is not known whether this sexual abuse was real, a sheer fabrication, or a cover for Canon Mignon's sexual exploitation of the nuns. Interestingly, a Dr Duncan examined the nuns during this period and found no evidence of possession or insanity.

The Lady Superior of the Ursulines was related to a member of the King's Council, and she used this connection, in collusion with Mignon and other townsmen of Loudon, to bring Grandier to trial again. On 6 December 1663, the King's direct representative arrived to study the situation, a move perceived as an affront by the local magistrates. At this point several nuns confessed that Grandier was innocent, but to no avail. Careful physical examination of Grandier revealed several areas of localized anaesthesia to pinpricks, which were a diagnostic sign of demonism and witchcraft, and he was burned at the stake on 18 August 1664.

Those who burned Grandier at the stake promised him that, if he vowed to keep quiet and not make any politically embarrassing statements before being consumed by fire, they would strangle him prior to his being burned. Although Grandier agreed, he was burned alive anyway, exclaiming as the flames engulfed him, 'Ah, you have cheated me!'

A similar intrigue involved the nuns of Louvier. One of the nuns,

Madeleine of Rouen, was impregnated by her confessor, Picart, who also prostituted her to other clergy, including a Vicar Boulle. After Picart's death, an intrigue against Madeleine ensued, with an epidemic of demon possession among her fellow nuns, and the demon Leviathan accusing her of sins through the mouth of a deliberately planted nun named 'Anne of the Nativity.' Again, there was much political machination, with plots and subplots, the end result being the life imprisonment of Madeleine; the exhumation of Picart's bones, which were thrown in a sewer; and the burning at the stake of Vicar Boulle on 21 August 1647.

Conclusions

The Catholic Inquisition is still with us, psychologically, because the fundamental psychodynamics of our culture have not changed since the last witch was burned in Scotland two hundred years ago. There could be several kinds of destructive witch hunts in the 1990s, with the targets being therapists alleged to have implanted false memories in their clients, or falsely accused perpetrators of Satanic ritual abuse. The psychology of Satan is also evident in the attitude of late twentieth-century psychiatry towards women with borderline personality disorder: the psychology of Satan is a fundamental element of the Western psyche and is acted out in many ways. This is but one of the lessons taught to me by my patients with Satanic ritual abuse memories, who clarified the psychology of Satan for me.

In treating Satanic ritual abuse survivors, it is important to focus on the underlying individual and cultural psychodynamics, not on the informational content of the memories. The purpose of this chapter has been to describe some of these dynamics, and to underline the point, developed in more detail in Part III of this book, that the therapist treating Satanic ritual abuse cases must maintain ideological neutrality and not identify with either the witches or the Inquisitors.

4

Non-Satanic Cult Activity in North America

In order to treat Satanic ritual abuse survivors effectively, it is essential to understand them within a broad context. In the previous chapters, I created a historical context; in this chapter, I review the nature and extent of known destructive cults and secret societies in North America today. If there were no known destructive cults of any kind in our society, the possibility of Satanic ritual abuse cults would be less likely.

It is an indisputable fact that animal-sacrifice cults are widespread in North America today, the best-known example being Santería, an Afro-Caribbean cult with Catholic admixtures. In 1987, Hialeah, Florida, became the first U.S. city to ban animal sacrifices, resulting in an eventual hearing in the U.S. Supreme Court in the case of the *Church of Lukumi Babalu Aye* vs *Hialeah* (*The Dallas Morning News*, 5 November 1992, p. 4A). A judgment was rendered by the Supreme Court in favour of the Santería Church.

Murders committed by cults have been prosecuted successfully in the United States. In May 1992, Yahweh Ben Yahweh, age fifty-six, and six followers were convicted of federal conspiracy charges in relation to activities of his cult called 'the Nation of Yahweh,' which included a business empire worth $8 million and thousands of followers in twenty-two states. Yahweh Ben Yahweh, who is black, was sentenced on 4 September 1992 to eighteen years in prison for ordering the killings of fourteen 'white devils' and wayward disciples.

On 20 January 1993, three members of a polygamist cult in Texas were convicted of the murders of three former cult members and a young girl. According to prosecutors, the murders were committed to bring on the Kingdom of God (*The Dallas Morning News*, 21 January 1993, p. 14A). The reality of deviant cults and their potential for violence was brought

to public attention by David Koresh and his Branch Davidian cult in Waco, Texas, in February, March, and April 1993. A former member of the cult described repeated drills in the practice of mass suicide by cyanide ingestion or shooting of oneself in the mouth, an account which tells us that Jonestown can occur again. The Branch Davidian siege received extensive worldwide media attention.

Interest in Satanism is apparently present in at least some prisons. In *Childs* vs *Duckworth*, a prisoner in Indiana filed suit to protect his right to hold meetings of The Satanic Brotherhood while in jail, but he lost in both the original trial and on appeal. Childs had a library of more than two hundred occult-related books in his prison cell and, besides holding Satanic study groups, wanted to burn incense and candles in his cell, and take out books on Satanism through interlibrary loan (Office of Criminal Justice Planning, State of California, 1989–90).

Perusal of the crime section of any bookstore will yield the interested reader numerous accounts of murders committed by members of small cults, many of which have a crude, makeshift, ritual element to them, and many of which were motivated by a theological system, as well as by power and greed.

The most obvious example of a large-scale well-organized human-sacrifice cult was the massacre of more than nine hundred men, women, and children in Jonestown, in Guyana, in 1978. This mass murder/suicide by ingestion of cyanide was rehearsed numerous times, led by Jim Jones. It was made possible by extensive abuse, intimidation, mind-control techniques, social isolation, and logistical control of cult members over a prolonged period of time. Had it not been reported by the media, the Jonestown massacre would likely have been dismissed as fantasy if recounted by a survivor in therapy in the United States.

Murders carried out by small groups of non-multigenerational Satanists have been successfully prosecuted, and ritually mutilated bodies have been recovered without prosecution of suspects, the most-often-cited example of the latter being a headless, ritually mutilated corpse found in Golden Gate Park in San Francisco. I have seen a number of photographs of ritually mutilated human bodies and mutilated animals hung in trees, as well as confiscated Satanic paraphernalia, in police displays at professional meetings. Those who argue that there is no physical evidence of Satanic crime are simply mistaken: the only aspects open to debate are the extent and the degree of organization of the crime (Blood, 1994).

Given the abundant information about crimes with Satanic elements,

convictions for murders by cults, and animal sacrifice by cults such as Santería, it is possible that Satanic murders are being committed in North America. The question is, 'How many?' If five Satanic human sacrifices are conducted in North America per year, it is easy to understand why no physical evidence has been found. If the number is five thousand, then we have a social problem on a very different scale, and the lack of physical evidence is troubling. Is it conceivable that a large number of Satanic human sacrifices could occur each year, and go entirely undetected?

Before concluding that the answer to this question is, 'No,' one should consider the quality of the initial police investigation in the Jeffrey Dahmer case, in Milwaukee. Over the months before Dahmer was finally caught, there were complaints from other residents in his apartment building about the smell of rotten meat and the sound of an electric saw. Dahmer accounted for these things by saying that his freezer had broken down and that he was remodelling in his apartment, when in fact he had murdered and cannibalized more than ten people.

Milwaukee police answered a call and interviewed Dahmer on the street, along with a naked underage boy who did not speak English and was bleeding from the rectum. They went up to Dahmer's apartment with the boy and interviewed Dahmer there, then left. The officers made jokes about homosexuals on the police dispatch after leaving Dahmer's apartment, and failed to notice both human body parts and photographs of dismembered corpses readily observable in other rooms in the apartment: the young boy was subsequently sexually assaulted, murdered, and cannibalized.

The Jeffrey Dahmer case tells us that we cannot reach any firm negative conclusions about the reality of multigenerational orthodox Satanic ritual abuse based on the present lack of objective evidence. We are prevented from doing so not simply because it is impossible to prove a negative, but because the quality and tenacity of much police investigation, and the quality of forensic-psychiatric investigation of dissociation, which might uncover extensive information hidden behind amnesia barriers, are suspect. In the case of law enforcement, any deficiencies are probably attributable to the allocation of resources rather than to a lack of investigative expertise; in the case of forensic psychiatry, the problem is disregard of MPD and dissociation.

What do we know about the structure and function of non-Satanic destructive cults currently operating in North America? I review this information briefly below, to provide a more complete contemporary context for understanding Satanic ritual abuse.

Structure and Methods of Destructive Cults

Various books provide a summary of the way cults such as the Moonies, Hare Krishna, and the Children of God operate (Andres and Lane, 1988; Appel, 1983; Galanter, 1989; Hassan, 1988; Melton and Moore, 1982; Robbins, 1988; Ross and Langone, 1988). These profiles are very similar to that of the Satanic cult described by Warnke in *The Satan Seller* in 1972.

The first feature is *deceptive recruitment*. The recruitment methods of destructive cults differentiate them from organized religions and small non-destructive sects and churches. When an individual is enticed into a destructive cult, he or she does not know the true nature of the organization at first, and finds out only when deeply entrapped. For instance, if a college student is being recruited on campus, an attractive member of the opposite sex may invite the recruit to a study group, party, or meeting of some kind, giving only a vague description of what is involved.

The first few times the recruit attends such meetings, they seem innocuous. The next step may consist of weekend retreats, involving a number of mind-control procedures. The recruit may be subjected to *love bombing*, in which vasts amounts of attention, positive feedback, and validation are provided. This technique is often combined with isolation from the outside world; sleep and/or food deprivation; repetitive prayer, meditation, chanting, or study exercises; and sharp withdrawal of attention and affection if the recruit questions the methods or the group's ideology.

The weekend retreats occur more frequently, and soon the recruit may move into cult housing. Step by step, the cult takes over the entire life space of the recruit. The degree of sensory deprivation, hypnotic study and meditation exercises, aggressive indoctrination, sleep deprivation, and oscillating reward–punishment intensifies until the recuit is no longer making independent decisions or exercising his or her critical faculties. The cult takes over control of the recruit's life, in terms of personal finances and relationships, sexual activity and partners, how his or her day is spent, and the city in which he or she lives.

By this stage, another key feature has been instituted: the recruit's family and all outsiders are defined as evil. *Isolation from family and friends* is enforced by cult doctrine, and people in the outside world are defined as agents of Satan. Many members of destructive cults lose contact with their families for years, and are threatened by the cult in various ways to ensure they do not contact family members in secret. Also, marriages to people within the cult can be arranged, in part to ensure the

future supply of indoctrinated children. The Moonies exemplify this practice: the Reverend Sun Myung Moon has conducted mass weddings in which thousands of couples were married at the same time, all of the marriages arranged by the Unification Church, and many of the husbands and wives never having met each other before.

Once the recruitment is completed, obedience is maintained, in part through a *hierarchical organization*, with a *charismatic leader* at the top. The recruit, at a low level in the hierarchy, does not have direct access to the leader, who is viewed as God, and is not privy to the inner workings or ultimate purpose of the cult. At higher levels, a small number of cult members, sometimes including a sexual partner of the leader, have access to the leader and understand what is truly going on. The leader of the cult may be sexually active with cult members on demand; otherwise, direct contact is discouraged.

Within the cult a system of promotions exists, based on performance as a recruiter and other qualities, with each step being perceived as an approach to enlightenment, divine favour, or transcendent love. All of these different recruitment and indoctrination techniques, according to Hassan (1988) and West and Martin (1994), result in a dissociation of personality, with suppression of the recruit's original character and creation of a cult personality that is emotionally blunted, incapable of independent critical thinking, and depersonalized and estranged from the individual's past.

Satanic Cults with Classical Recruitment Techniques

Hassan's (1988) description of Linda Blood's short-term involvement in the Temple of Set, during which time she was a sexual partner of Michael Aquino, meets many of the criteria for a destructive cult noted above, even though there is no evidence that this cult has engaged in criminal activity. Linda Blood (1994) has provided a further description of her experience. Aquino and his wife and high priestess, Lilith, were the targets of a multijurisdictional investigation concerning ritualistic child abuse in northern California in 1989 (Blood, 1994; Langone and Blood, 1990).

In his book *The Satan Seller*, Warnke (1972) describes recruitment techniques and cult organization that meet all of the standard criteria for a destructive cult. He himself was a recruiter, and rose in rank during his period of involvement. The initial hook was usually drugs, sex, and parties, with expensive homes in California being used as sites for the

recruitment parties. Teenagers, especially girls, were enticed into attending several of the parties, given lots of free drugs, then gradually turned over to someone inside the cult for training, with gradual exposure to increasingly deviant and explicitly Satanic rituals. The cult had a hierarchical structure, and various degrees of initiation, although in this cult the identity of people at the top was kept secret by this cult. It is clear from *The Satan Seller* that Warnke's experience was highly distorted by an amphetamine psychosis; therefore, one cannot assume that anything in the book is real. Nevertheless, much of the detail is consistent with what is known about destructive cults, and not inherently implausible.

I have worked with several people who independently describe functioning as recruiters for Satanic cults in the fashion described by Warnke, with initial enticement through drugs, alcohol, and parties, followed by turning the new recruit over to someone else in the cult. New members were held in the cult through threats, blackmail, drugs, and the addictive rush experienced during rituals.

The allegations made by patients and clients in therapy concerning Satanic ritual abuse are not simply idiosyncratic: they often conform to known characteristics of destructive cults in general. The description of multigenerational orthodox Satanic cults in terms of structure and function is also similar to what we would expect to hear from a person born into the Way International or the Children of God. The thing that is different about Satanic human-sacrifice cults is the degree of deviance, not the structure – and, of course, the lack of objective verification of their existence.

I now briefly describe one destructive cult, the Unification Church, to illustrate the magnitude of the influence of such cults.

The Unification Church (The Moonies)

The Unification Church is run by the Korean-born Reverend Sun Myung Moon, who served thirteen months in the federal penitentiary in Danbury, Connecticut, for a 1982 conviction for tax fraud (Hassan, 1988). Hassan describes the findings of the Fraser Report, the published findings of the U.S. House of Representatives Subcommittee on International Organizations of the Committee on International Relations, chaired by Rep. Donald Fraser. The report was published on 31 October 1978.

The Fraser Report describes direct relationships among Moon; his right-hand man, Bo Hi Pak; the 1961 coup in Korea; and the founding of the Korean CIA, as well as an ongoing relationship between Moon and

the Korean CIA. Hassan states that Moon is also connected to the Japanese crime syndicate Yakuza and its leader, Yoshi Kodama. The Unification Church is very wealthy and well connected and has extensive investments and government contacts. It owns *The Washington Times*, a newspaper Hassan states was repeatedly described by Ronald Reagan as his favourite newspaper: two of the top executives at *The Washington Times* are Bo Hi Pak and Han Sang Keuk, both of whom were directly involved in the coup in Korea and formation of the Korean CIA. Moon's business operations include exportation of ginseng and manufacture of M-16 rifles.

The Moonies have an active political agenda, the ultimate goal of which is totalitarian rule of the world by Moon, and they are estimated to spend hundreds of millions of dollars on recruitment and the purchasing of influence. This brief summary of the Unification Church's activities is intended to illustrate the fact that destructive cults are a multibillion-dollar industry in North America, and that they have enormous wealth and influence, extensive government contacts, and sophisticated intelligence capabilities.

All these facts about known, successfully prosecuted destructive cults make it conceivable that Satanic human-sacrifice cults could be operating in secrecy through a combination of bribery, financial power, political connections, and intelligence expertise. Who would have thought that the favourite newspaper of a president of the United States would be owned by a Korean cult leader whose followers believe him to be Jesus Christ?

Next, I briefly describe the Masons, who are regarded by many as having provided the archetypal model for the organization of secret societies over the last five hundred years.

The Masons

Everyone has heard of the Masons and the Shriners, and I remember attending the Shrine Circus as a child. The Masons are a known fraternal order about whom no public allegations of criminal activity or ritual abuse have been made. The Masons illustrate the fact that secret societies, cults, and fraternal orders in existence for hundreds of years can continue to flourish in North America in the 1990s.

Masonic symbols can be found in at least two places in our society: on the back of the U.S. dollar bill and in Walt Disney's *Fantasia*. What these symbols are doing in *Fantasia* I do not know, but they appear on the cur-

tain that is shown immediately before and after a segment in which a seductive female hippo becomes the victim of a Satanic-human sacrifice ritual by a coven of thirteen demonic alligators. This segment is followed by the overt emergence of the bat-winged medieval Satan, and the torment of damned souls in Hell. The point here is that occult symbols can be found in many different places in our society, and symbols were present in our popular culture long before they began to appear in the drawings and memories of Satanic ritual abuse survivors.

The Masons originated officially in 1717 with the founding of the Grand Lodge of England (Fisher, 1988); however, their origins appear to go back to the trials of the Knights Templar from 1307 to 1314: Jacques De Molay, Grand Master of the Knights Templar, was executed by the Catholic Church in 1314, but before he died he apparently founded Hermetic or Scottish Masonry, with lodges in Naples, Edinburgh, Stockholm, and Paris. The beliefs and practices of the Masons are secret, and initiates must pass through degrees of initiation before they are made privy to the highest doctrinal secrets and ceremonies.

The Masons have an esoteric doctrine based on Gnosticism, Egyptian mythology, and other influences, and they perform secret ceremonies based on this doctrine. The history of the Masons is intertwined with the political history of western Europe and North America in a way that few appreciate, according to Fisher (1991). The Masons are generally regarded as a philanthropic social club with harmless costumes and ceremonies.

I have personally worked with alter personalities who allege that their function is the training of young initiates in white-supremacy groups which sound like variants on Masonry, and I had never heard the term 'demolay' – a trainer of young initiates – before I met these alter personalities. As this example illustrates, clinical experience with MPD patients leads one to consider that there may be some objective reality to their ritual abuse memories.

Could Satanic Human-Sacrifice Cults Exist?

Given the historical and contemporary background reviewed in the first four chapters of this book, it is possible that human sacrifices could be conducted by Satanists in North America today. No one can reasonably dispute the fact that twenty or thirty human beings could be ritually murdered in North America per year without any physical evidence turning up. The victims could be drifters, runaways, missing persons, or

unregistered births: Langone and Blood, in their book *Satanism and Occult-Related Violence: What You Should Know* (1990), point out, for instance, that out of 22,827 missing children reported to the National Center for Exploited and Missing Children between 13 June 1984 and 30 June 1989, 9,348 remained unaccounted for.

Langone and Blood also state, citing Cozolino (1989), that, out of a total of 270 cases of sexual abuse in day-care centres, 36 substantiated cases of ritualized abuse were noted (13.3 per cent of the total). Langone and Blood further state, citing Charlier and Downing (1988), that, out of 91 cases in which individuals were charged with crimes involving ritual abuse between August 1983 and September 1985, 23 convictions were obtained, a conviction rate of 25.3 per cent as compared with the national conviction rate of 4.3 per cent for serious crimes, reported by the Bureau of Justice Statistics (Langone and Blood, 1990).

In a related bibliography, Linda Blood (1989) provides a lengthy list of articles from the popular media on Satanism, and in a list of convicted or alleged perpetrators of Satanism/occult-related crimes, she gives the names and locations of crimes of forty-five individuals convicted for ritualized child abuse, murders with Satanic components, and cannibalism. Without reviewing all of these cases individually, one cannot tell the nature of the Satanism involved, and none of the convictions provides evidence of well-organized multigenerational Satanic cults.

Since there are numerous destructive cults, both small and large, in our society; since animal sacrifice is widely practised by devotees of Santería, who have successfully taken their case to the Supreme Court; since murders by members of deviant cults have resulted in convictions; since many Satanic crimes have been successfully prosecuted; and since systematic human sacrifice has been practised throughout history, including by the Nazis in the twentieth century, and apparently currently by the Serbs, it is difficult not to conclude that Satanic human sacrifices could be occurring, at least on a small scale, in North America in the 1990s.

Another excellent resource concerning Satanic crime is the Office of Criminal Justice Planning, State of California, *Research Update* (1989–90). This is a balanced document which cites many sources, outlines the polarized opinion on Satanism, gives good summaries of the opinions at both poles, and provides interesting statistics and case examples. It analyses the conviction of Clifford St Joseph for the murder of a man in San Francisco whose body was found to contain very little blood and exhibited patterned injuries on the wrists, back, ankles, and buttocks; a pentagram carved on the chest; one mutilated testicle; and melted wax in the

right eye. Involved witnesses claimed that the murder was part of Satanic cult activities, but no information is provided about the extent of evidence supporting the existence of an organized cult. *Research Update* makes the point that conviction was based on solid, conventional police investigation, and that the convictions were for first-degree murder, sodomy, and false imprisonment, not for Satanism.

Although Satanic human sacrifice may be going on in North America on a small scale, survivor memories also include a large amount of distortion. If all the memories being recovered in therapies in North America today were real and accurate, thousands, or tens of thousands, of babies would have to be sacrificed per year: this is just not possible. In *The Osiris Complex* (Ross, 1994), I describe a patient who believed that her mother had committed suicide, and who went over to visit her parents' home numerous times subsequent to this suicide. Each time, the patient looked directly at her mother but believed that her father had quickly remarried and the woman was her new stepmother: we discovered what was going on only by contacting a previously unknown alter personality in the background, who was deliberately putting these ideas and perceptions into the host personality's mind.

I recently had the experience of following two nurses into a patient's room on our Dissociative Disorders Unit at Charter Behavioral Health System of Dallas, then being involved in care of the patient's self-inflicted wound. Another patient on the unit observed the injured patient's room-mate walk out of the room and come down to the nursing station to get us; she then observed the nurses enter the room first, followed by me; shortly after this, one of this woman's alter personalities came out and became hysterical and began banging her head on the door at the end of the hallway, screeching that I had killed the patient. This alter personality believed that I was a member of a Satanic cult who had committed a sacrifice inside the hospital, although she knew me well and had direct observational evidence that the wound could not have been inflicted by me. Several days later, the same patient's host personality asked if I would take over her care because she was unhappy with her attending physician.

In another case, I talked with a woman who had a clear, fully formed memory that seemed absolutely real to her, although she realized that it was not possible. This woman had a dissociative disorder, and no hint of psychosis or delusional thinking, nor did she have a history of drug abuse. She did not claim a ritual abuse history; rather, her memory was of having her head cut off.

Two other patients I worked with believed that they had cancer, and gave the names of their doctors, type of cancer, and the clinic where they were treated, and one case specified the type of surgery performed. Checking records at these clinics established that neither of these women ever had cancer; however, they weren't consciously lying, but actually had memories of these non-existent events. In another case, a woman with a background of multigenerational orthodox Satanic ritual abuse, who believed she had been raped by Satanists countless times, was shown by gynaecological examination to have an intact hymen. Another woman claimed that her children had recently been murdered by a Satanic cult, that the FBI had confirmed the murders in person to her, and that she had talked on the phone with the morgue that was holding the bodies; however, the children were still alive, as proven by the therapist's conversation with them on the phone. This woman also claimed that her husband was in prison on charges of sexually abusing his daughters, which was disproved by a phone conversation with the husband, during which he described a long-standing history in his wife consistent with a *DSM-IV* diagnosis of factitious disorder.

If a patient can misinterpret unremarkable behaviour by a doctor directly observed inside a hospital as a Satanic murder, or report her children dead when they are still alive, there must be a tremendous amount of distortion in the memories reported from twenty or thirty years ago by frightened-child alter personalities. According to the polarized debate about Satanic ritual abuse, there are only two possibilities: it is all real, or it is all hysteria. Satanism is actually, I believe, a complicated mixture of real memory, confabulation, cultural myth, and misinformation.

Conclusions

The information emerging in therapies across the country, even if only partially accurate, implies that our society contains Satanic cults and secret societies. This is hard to believe, based on daily living in the world, but it is consistent with a great deal of documented information about destructive cults.

We do know for a fact that there are many destructive cults active in North America today. Many are based on ideas one would think it impossible for anyone to believe, such as the UFO cult in Long Beach, California, that limits personal possessions to items which can fit in a valise of specified size, dictated by the cargo space limitations of the

Mother Ship that will arrive to pick up cult members. I remember watching a slide show on cults presented by Dr Louis Jolyon West, an expert on cults (West, 1989; West and Martin, 1994), at a meeting in Long Beach, California, several years ago, and being impressed by a cult in which women recruit new members through prostitution, fully believing that their ends justify their means, and that Jesus approves of their prostitution.

I think we should be in a state of uncertainty about the sociological reality of Satanic ritual abuse. There are many survivor memories of Satanism, but the potentially believable elements are mixed up with much that is unbelievable. The dissociative distortions of thinking inherent in multiple personality disorder make all reports about the past by MPD patients suspect, and patients early in treatment are always confused about what actually happened in their childhoods. Their memories always remain fragmented until extensive therapeutic work has been done: whether this work reconstitutes reality or reifies an illusion, or both, is unknown. Anyone who thinks he or she knows the extent of Satanic ritual abuse in North America today is, I think, mistaken. It is *possible* that multigenerational orthodox Satanic cults are operating today in North America, given everything else we know about destructive cults and the history of the human race, but this does not prove anything one way or the other. The major point I am making in *Satanic Ritual Abuse* is that the therapist must take a position of ideological neutrality in order to work effectively with individuals claiming past involvement in Satanic cults: it is important not to accept or reject too much of the sociological reality of the ritual abuse memories. As the information in this chapter emphasizes, it is realistic to at least *consider* the possibility that some elements of the memories could be historically accurate.

II
Satanic Cults Today

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5

Five Levels of Satanism

There are different levels and degrees of Satanism, and it is not possible to treat victims of 'Satanism' without taking this into account. The same variations are present in any human activity. Consider drugs, for instance: some individuals take a transient interest in street drugs during adolescence; others become lifelong addicts and dealers, totally devoted to their god, cocaine. For the latter individuals, cocaine determines not just their state of consciousness, but who they know, how they earn money, and how long they live, as is clear from the fact that North American hospitals are filling with crack babies as the already enormous drug problem in North America increases.

In comparison with our knowledge of cocaine, our understanding of the nature and extent of Satanic ritual abuse is rudimentary; data on the drug trade are widely available, whereas proof of the existence of widespread organized Satanic cults practising human sacrifice is lacking. Despite this tenuous external context, it is important that those trying to treat victims of Satanism understand the subjective context of the patient and clarify the different degrees of involvement and forms of 'Satanism.'

Involvement can be divided into five distinct levels. An individual can shift from one level to another, or be involved in more than one level at a time, but the five levels provide a general framework for putting treatment in perspective. The five levels are:

1 Isolated criminal deviants;
2 Teenage dabblers;
3 Non-criminal public Satanic churches;
4 Narcosatanistos;
5 Orthodox multigenerational Satanic cults.

There is substantial evidence, including extensive physical evidence gathered by police and criminal convictions, for the first four levels of Satanism (Blood, 1994). It is only the fifth which is unproven. Below, I describe each of the five levels.

Isolated Criminal Deviants

Satanism is in the news these days, with feature articles appearing in newspapers throughout North America; in addition, movies, books, and rock lyrics and videos frequently portray Satanic/demonic imagery and activities. The sacrifice of a nude woman on a Satanic altar; the goat's head; the inverted pentagram; and the use of ceremonial daggers, cloaks, and chalices in Satanic ceremonies are all well known within popular culture.

It is easy to understand how a mentally ill or disaffected deviant could acquire knowledge of Satanism – many large chain bookstores stock books like Anton LaVey's *The Satanic Bible* (1969), and every large city has at least one occult bookstore stocking numerous titles on Satan, demons, magic, and the black arts. Given this, it would be surprising if at least some serial killers did not adopt Satanic themes.

No special knowledge is required to understand the isolated criminal Satanist. Such individuals do not belong to any established organization or cult, and they probably adopt the trappings of Satanism for kicks, as part of a psychosis or simply for the shock value. Within the criminal-justice system, such people can probably be best understood and dealt with in the same way as any other person committing equivalent crimes.

The same is true of non-criminal adolescents who pursue an individual interest in Satanism. They may doodle Satanic imagery in their school notebooks, erect a makeshift altar in a bedroom, read the odd book, and listen to heavy metal-music, but they are not seriously involved in Satanism. No public policy is required to deal with the isolated individual involved at this level since criminal activity is rarely a result and, when it is, no special knowledge, investigation, or prosecution is required.

The chief example of a serial killer with Satanic overtones is Richard Ramirez, 'The Night Stalker,' who was convicted of murders in California. According to public accounts, Ramirez was never involved in an organized Satanic cult. He carried out his crimes alone, entering houses at night, then raping and/or murdering whomever he found there.

Ramirez was inspired by the rock group AC/DC, and especially by

their album *Highway to Hell,* which contains a song called 'Night Prowler.' Ramirez spray-painted pentagrams on the walls of some of his victims' homes, mutilated some of the bodies, displayed an inverted pentagram on the palm of his hand in court, and, after killing some of his male victims, raped their wives and made them swear allegiance to Satan.

I listened to AC/DC's *Highway to Hell,* and made transcripts of the songs 'Night Prowler' and 'Highway to Hell' to determine whether they are Satanic in nature: they aren't. 'Highway to Hell' plays on the phrase 'hell on wheels.' There is nothing more to this song than a teenager planning to drive his car fast and shock his parents with references to Hell. The song 'Night Prowler' is also not the least bit Satanic in nature. The opening lines are weakly poetic in a convention-shocking fashion that is a minor equivalent of T.S. Eliot's 'The Love Song of J. Alfred Prufrock,' with none of the technical innovation. There are faint echoes of *The Wasteland* in the song, and no references to demons, Satan, pentagrams, cults, or anything else that could be construed as Satanic. AC/DC targets its music at disaffected teenagers who want to be different: since long hair, beads, and pot-smoking are insufficient for this purpose in the 1980s and 1990s, heavy metal fills the gap as counterculture. There is, in fact, nothing 'counter' about AC/DC, any more than there is about Lawrence Welk, since both produce music for the mass-market audience. Though 'Night Prowler' may have inspired Richard Ramirez's crimes, it is not explicitly Satanic in nature, and has nothing to do with organized Satanic crime. The fact that all heavy-metal music has been categorized as 'Satanic' by some Christian fundamentalists, and blamed for causing 'Satanic' behaviour, underlines the need to be clear about the different levels of Satanism.

A recent case in Corpus Christi, Texas, is an example of a non-Satanic ritual murder carried out by a lone offender. I wonder whether the killer, Elaine Shook, age thirty-seven, has an undiagnosed dissociative disorder or a ritual abuse history. Shook drowned her four-year-old son in a creek, in what police described as a ritualistic slaying (*Dallas Morning News,* 27 July 1993, p. 20A). Authorities found makeshift constructions near the pickup truck in which the boy's body was found and said that the woman described them as 'altars.' She also told them that a dragon was inside her son. Nueces County medical examiner Lloyd White is quoted as saying, 'It looked like a ritualistic sort of thing. All these little piles of objects had been stacked up in the sand and so forth.'

There are many examples of isolated criminal deviants involved in

'Satanism': Lloyd Gamble, age seventeen, was murdered with a shotgun by his brother in Monroe, Michigan, on 2 February 1986. Police confiscated ceremonial robes, an inverted crucifix, and Satanic materials during the investigation, but concluded that the murderer did not belong to a cult and had acted alone. Arthur Lyon, in his book *Satan Wants You* (1988), quotes the murderer as saying that he killed his brother in order to 'release him to a higher plane of consciousness.' As is true of the crimes of The Night Stalker, such deviant acts do not provide evidence of the existence of organized Satanic cults.

Sean Sellers is another teenager fascinated with Satanism who committed murder: he is the youngest person on death row in the state of Oklahoma (Larson, 1989). He murdered a convenience store clerk on 8 September 1985, and his parents on 5 March 1986. Sean Sellers built a Satanic altar in his bedroom and was briefly involved in blood-drinking ceremonies with several other teenagers. He had a substance-abuse problem but was never involved in an organized cult for a prolonged period of time.

Ricky Kasso, an adolescent living in the suburb of Newport on Long Island, New York, was involved in a small Satanic cult called 'The Knights of the Black Circle' along with a few other teenagers, and was arrested for digging up a grave. Ricky and his accomplice, James Toriano, tortured another teenager, Gary Lauwers, for three hours, gouged out his eyes, and forced him to say 'I love you, Satan' before killing him (Larson, 1989). Kasso hanged himself in jail.

David Berkowitz, who committed the Son of Sam murders, is the subject of a book by Terry Maury entitled *The Ultimate Evil* (1987). The thesis of the book is that Berkowitz, a serial killer, was linked to a Satanic organization called 'The Process,' and that he did not act alone. Maury's book, the jacket blurb states, convinced Queens district attorney John J. Santucci to reopen the case. Berkowitz was convicted, and the conclusion reached during the investigation and at the trial was that he had acted alone. This story emphasizes that even apparently isolated deviants may be connected to organized Satanic groups, and that these connections, if they exist, may be missed without careful, informed investigation.

Isolated deviants involved in Satanism have committed numerous crimes in North America. Police and other law-enforcement officials may see more of such crimes, including murder, assaults, animal killings, break-ins, and drug-related offences. Police departments should be knowledgeable about the range of Satanic criminal activity because it

may not be immediately apparent at a given crime scene what level of Satanic activity was involved.

Prosecutors may be reluctant to bring up the Satanic component of isolated deviant crimes, fearing that it may weaken or discredit their cases. In many cases, this component may not be an integral part of the crime, and the prosecution can be effectively handled in the usual fashion, based on the actual crimes committed. However, in terms of further investigation and prevention of future crime, a Satanic crime committed by an isolated individual is one thing, but one committed by a highly organized secret group of adults is another entirely. Clearly, the level of knowledge, commitment of resources, and difficulty of ongoing investigation are much greater in the case of organized crime, whether it is committed by the Mafia, by the Medellín cartel, or by a Satanic cult.

Teenage Dabblers

The term 'teenage dabbler' is often too mild for the actual activities that occur: Sean Sellers and Ricky Kasso, for instance, could be described as dabblers. The routes of entry of disturbed and vulnerable teenagers into Satanism are varied, but the background of such children often includes physical, sexual, and emotional abuse; neglect; and severe family dysfunction (Larson, 1989; Lyon, 1988; Raschke, 1990). Police officers knowledgeable about occult crime say that teenage dabblers in Satanism usually fit a common profile (Metz, 1992).

As well as having backgrounds of abuse and neglect, many such teenagers have substance-abuse problems; are doing poorly in school or have dropped out; are isolated and marginalized in relationship to their peers; and feel unloved, unwanted, and impotent.

Teenage involvement in fantasy role-playing games, often cited as a risk factor for involvement in Satanism, may go far beyond any healthy or normal level, occupying many hours of every day, and much of the weekends. Games may become increasingly intricate, and crimes, including theft, assault, rape, and murder, may begin to be acted out within the context of the game. It doesn't necessarily follow that fantasy role-playing games or heavy-metal music *causes* deviant behaviour, but it seems possible that either may contribute in some way, and since certainty is not possible, dogmatic opinions are not warranted.

One teenage dabbler I met had reached the level of blood-drinking rituals and group sex with other teenagers. In my assessment of him, I determined that he was capable of escalating his activities to murder.

This boy did not fully fit the profile described above, as he was not intensively involved in fantasy role-playing games. He owned a good deal of Satanic paraphernalia, including candles, a chalice, pentagrams, and a fake skull, which he showed me, and he had a dissociative disorder.

The boy had an angry entity inside him which he believed was a demon. It talked to him in a deep, angry voice; instructed him to do violent things; and, he thought, took control of his body during periods for which he was amnesic. During these periods, according to descriptions later related to him by friends, he 'acted different,' was angry and hostile, and was violent to a minor degree. The boy had conducted specific rituals to command the demon to go out into the world and cause the accidental death of a relative with whom he was in conflict.

Since this had not worked, he planned, next, to conduct a more powerful ceremony in which the demon would take full possession of him. He and the demon acting in perfect concert would then murder the relative with a dagger, but it would really be the demon doing it, he said. This case was dealt with by supportive therapy, limit-setting on his Satanic activities, foster placement, and family therapy, with apparent short-term success.

Also, this teenager had no knowledge of how his mother's scissors – a potential murder weapon – came to be hidden in his bedroom, and he was amnesic for rituals he had conducted there, which, the boy concluded from physical evidence he and his mother had found, involved burning things in candle flames. All these details were confirmed by the mother during the assessment.

If the degree of conflict in the boy's family system had escalated without an intervention, or had the relative in question been more overtly abusive, a murder could have occurred. Satanism wouldn't have been the cause of the murder, but it probably would have contributed to the crime. It appeared to be providing a technique for crystallizing the dissociative disorder so that a murder could be committed while responsibility was disavowed.

Although there are no adequate statistics available, it appears that a substantial number of teenagers in North America are dabbling in Satanism up to the level of ritual sacrifice of animals, group sex and drug use, drinking of each other's blood, and sexual exploitation of more vulnerable group members. This is a matter of serious concern. It is evidence of the cultural sickness of our society, but not of the existence of organized multigenerational Satanic cults.

A man who, until recently, might have been regarded as a teenage dabbler in Satanism is currently charged with the murder of two teenagers in Ennis, Texas (*The Dallas Morning News*, 12 August 1993, p. 31A). Jason Massey, age twenty, is accused of murdering Christine Ann Benjamin, age fourteen, and her fifteen-year-old step-brother, James Brian King. Christine's body was found decapitated, with both hands cut off, and these missing parts have not been recovered. Massey is accused of sending pictures of mutilated bodies and letters decorated with Satanic symbols to another girl, Roxanna Garcia, and Garcia's family members think Massey killed their family dog and used its blood to write threatening messages on their car windshield. Police acknowledged that the threatening letters to Garcia existed but had done nothing other than warn Massey to stop. An arrest-warrant affidavit alleges that Massey told a friend he wanted to have sex with Benjamin, kill her, and mutilate the body: the pattern of mutilations on the body are said to match those Massey described to his friend. The arrest affidavit also describes a 'Satanic bible' with girls' names in it, found by police (*The Dallas Morning News*, 7 August 1993, p. 1A). Massey is said to have liked to kill and decapitate cats and dogs, and store their heads in a rusty metal cooler in the woods.

The *Massey* case illustrates that teenage dabblers in Satanism may commit capital crimes. Captain John Knight of the Sheriff's Department is quoted as saying that there are twelve teenagers known to be missing in Ellis County alone, the county in which the bodies of Christine Benjamin and James King were discovered, and that many phone calls from the anxious parents of missing teenagers were received before Christine Benjamin was identified from X-ray records (*The Dallas Morning News*, 31 July 1993, p. 1A).

Non-Criminal Public Satanic Churches

There are several Satanic churches in North America which are constitutionally protected under the freedom of religion. They are distinct from various New Age white-witch groups like Wicca, which espouse a pagan nature philosophy and do not recognize Satan, worship evil, or commit crimes. Satanic churches practise explicit Satanism according to a well-articulated doctrine. They worship Satan and use Satanic paraphernalia such as altars, robes, pentagrams, and other symbols in planned, structured rituals. They have written doctrine and usually produce a newsletter. They are better described as small cults rather than as

churches. The two best examples are the Church of Satan, run by Anton LaVey, and the Temple of Set, run by Michael Aquino.

The Church of Satan owes much to Hollywood. Its founder has cultivated relationships with movie stars, a theatrical appearance, and a readership for his books, but he runs a tiny organization compared with those of cult leaders like the Reverend Moon.

LaVey's grandmother was born in Transylvania and told him many stories of the occult when he was a child. As an adolescent he accompanied an uncle to Germany at the end of the war, where he developed an interest in horror films: according to Schwarz and Empey (1988), one of these horror films was about a secret society of Satan worshippers. Upon his return to the United States, LaVey read Aleister Crowley and studied the occult intensively.

One of LaVey's early jobs was as a lion tamer; he then became a circus musician. As 'Professor Anton Szandor,' LaVey rode into town on a flatbed truck, leading the circus procession, and during this period he dressed flamboyantly even when not at work. He went on to play the organ and other instruments at amusement parks, and then at striptease clubs.

In the late 1940s, LaVey apparently faked his educational credentials in order to get into college to avoid the Korean draft, took courses in criminology, then started work as a photographer for the San Francisco Police Department in 1951. Schwarz and Empey feel that LaVey's disturbing work as a police photographer led him to conclude that God does not exist and that the world is ruled by Satan. LaVey left the police department in 1955, and cultivated an increasingly eccentric and flamboyant persona until he founded the Church of Satan on 30 April 30 1966 – Walpurgis Night, an important pagan holiday appropriated by Satanists as a Satanic holiday. With flamboyance and grandiosity, LaVey adjusted the Roman calendar on 30 April 1966, declaring that that day be known henceforth as 'I Anno Satanas' (Larson, 1989; Lyon, 1988; Schwarz and Empey, 1988).

A photograph in *Satan Wants You* (Lyon, 1988) shows Susan Atkins, who three years later confessed to licking blood off the knife that killed Sharon Tate, topless with Anton LaVey and three other witches, with an inverted pentagram on the wall in the background. Atkins played the role of a vampire in LaVey's 'Witches' Sabbath' topless show, depicted in the photograph. As is often the case with teenage dabblers, participation in non-criminal public Satanism may be a first step to involvement in serious crimes.

LaVey's career peaked in the late 1960s, during the period in which the

the Satanic movie *Rosemary's Baby* and LaVey's book *The Satanic Bible* (1969) appeared, but he has been in decline since then. His life contains all the necessary elements of a television soap opera, and he is best characterized as an anti-bourgeois showman whose act includes the trappings of Satanism. His Satanic rituals, for which attendees are charged admission, involve no criminal activities.

A less well-known figure is Michael Aquino, a U.S. Marine who broke from the Church of Satan and founded the Temple of Set in June 1975. Aquino is viewed as the supreme representative of Set/Satan on earth, within the doctrine of the Temple. His small cult is more austere, disciplined, and intellectual than LaVey's, and is a minor force in the overall sociology of cults in North America. The Temple of Set has neo-Nazi overtones which are characteristic of a range of right-wing/white-supremacist/paramilitary cults (Blood, 1994): some of these groups may be connected to orthodox multigenerational Satanic cults, as evidenced by MPD patients who have described Satanic ritual abuse perpetrated on them as children by the Ku Klux Klan. Non-criminal public Satanic churches are protected under the constitution and can acquire tax-exempt status.

Narcosatanistos

The Narcosatanistos are described in Carl Raschke's book *Painted Black* (1990). They are an apparently widespread group of drug smugglers known to the population on both sides of the Texas–Mexico border. Narcosatanistos represent an intermediate level of activity between isolated deviants and teenage dabblers, and multigenerational orthodox Satanic cults. They exist, are organized, and carry out numerous crimes, and they are connected to well-organized international drug cartels.

The murder of Mark Kilroy – a young, white, middle-class Texan pre-med student – by Narcosatanistos occurred in Matamoros, Mexico, on 14 March 1989 and received worldwide attention in the media. The murder was carried out by a group of drug runners led by Adolfo de Jésus Constanzo, and Kilroy's body was eventually discovered on a ranch in Mexico, where it had been ritually dismembered, boiled in a pot, mixed with animal blood, and cannibalized. The killers believed that this and other ceremonial murders they committed would provide them magical protection against police bullets; their belief was based on a mixture of several different cult religions, including Santería, Palo Mayombe, and Satanism, practised by Constanzo and his followers.

The Matamoros murders provide conclusive proof of the existence of well-organized groups of criminals practising ritual murder. The Narcosatanistos are not pure Satanists, and their primary interest may be drugs, money, and power; nevertheless, their activities make it impossible to argue that no bodies or other conclusive physical evidence of ritual murder has ever been found in North America.

The existence of the Narcosatanistos, for whom the Matamoros murders are likely only the tip of the iceberg, is publicly proven, and cause for great concern. Constanzo had recruited a Texan university student named Sara Villarreal Aldrete to function as a high priestess in his cult, and to lure sexual victims into his grip. According to Mexican police, Aldrete exhibited signs and symptoms of multiple personality disorder, and according to her father, Israel Aldrete, she kept Santería paraphernalia in her room. The connection between Satanic ritual abuse and multiple personality disorder is explained in detail in chapter 6.

Orthodox Multigenerational Satanic Cults

The book *Suffer the Child* by Judith Spencer (1989) provides an example of the Satanic childhoods therapists are hearing about. Orthodox multigenerational Satanic cults, as described by the patients, go back at least three or four generations. There is no consistent information being reported by therapists at workshops or meetings about any tradition going farther back than that, but the grandparents of survivors who are currently in their thirties and forties are said by survivors to be involved. In all discussions of Satanic ritual abuse, one must not forget that there is no objective public proof of the existence of such cults.

I have never met a therapist or mental-health professional currently working with ritual abuse survivors in North America who had had an interest in Satanism or Satanic cults prior to hearing about them from clients. We had had no knowledge of Satanic holidays, Satanic hand signals, or human sacrifice in North America until our clients began telling us about them. Prior to patients' disclosure of Satanic ritual abuse, most of us had no more knowledge of Satanism than the average person. From this starting-point, in less than a decade, mental-health professionals working with dissociative disorders have acquired a substantial body of information about Satanic crime in North America, albeit information that has not been objectively verified.

Consider, for a moment, the possibility that at least some memories of Satanic ritual abuse are based on accurate recall of real events; if such

were the case, therapists completely untrained in the methods of interrogation, criminal investigation, or anything of the kind, would be society's primary agents for gathering of information about a large, highly organized criminal underground (Gould, 1992; Nurcombe and Unutzer, 1991; Ryder, 1992; Stone and Stone, 1992; Young, Sachs, Braun, and Watkins, 1991). This situation makes no sense as a societal plan for combating Satanic crime: an analogous absurdity would be to imagine a situation in which little systematic police or FBI investigation of pornography and prostitution was taking place: therapists would be hearing about such activities, but there would be no objective proof that any of it was real.

I should define what the therapeutic community means by an orthodox multigenerational Satanic cult. Such cults, which I must emphasize yet again have not been proven to exist, are highly secretive, highly organized underground operations in which leadership is passed on within families. Members are recruited into the cult from participating families in early childhood and are subjected to sophisticated terrorization. Ritual activities involve child abuse; group sex; drug abuse; animal and human sacrifice; Satanic altars, chalices, robes, and other paraphernalia; and the observance of special dates and holidays.

The leaders of orthodox multigenerational Satanic cults are, at once, paedophiles, drug dealers, pimps, murderers, cult leaders, and rapists. Babies are sacrificed in the cults' ceremonies, and members known as 'breeders' are ritually impregnated to provide babies for sacrifice. These cults are described by survivors as operating throughout North America and western Europe, and their membership is said to include physicians, morticians, politicians, police officers, and other high-ranking members of society. According to survivor accounts, the cults have infiltrated day-care centres, child-protection agencies, the mental-health professions, and government, and they are linked together in an international network.

This operating definition of an orthodox multigenerational Satanic cult has been reconstructed by therapists from survivor memories. Non-multigenerational Satanic cults are also alleged to exist; they recruit teenagers and conduct human sacrifices, and may or may not be linked to the international network. Based on the number of survivors recovering memories of such cults in North America, cult membership would have to be at least in the tens of thousands, and the number of human sacrifices conducted per year in North America would have to be at least in the thousands. None the less, no authoritative body, agency, or professional society has endorsed the reality of orthodox multigenerational Satanic cults.

Satanic cults are a problem, whether they are real or not: if they don't exist, the survivor pseudo-memories pose a serious problem about the reality of all childhood trauma memories. Setting aside the problem of whether orthodox ritual abuse memories are real, it is not productive to talk about 'Satanism' in general. Rather, it is essential to understand the different levels and degrees of Satanic involvement, as clarified in this chapter.

6

Satanism and Multiple Personality Disorder

Satanism and multiple personality disorder are connected in so far as many alleged ritual abuse survivors in therapy have MPD. Why is this the case? To grossly oversimplify, there are two possibilities: either ritual abuse causes MPD, or MPD causes false memories of ritual abuse. These possibilities are not mutually exclusive. In order to think about these matters, one must first have some understanding of MPD, the quality of the current scientific literature on MPD, and the political controversies in psychiatry concerning MPD, all of which have evolved independently of consideration of the issue of Satanic ritual abuse.

The Official Definition of Multiple Personality Disorder

The diagnostic system of the American Psychiatric Association is codified in a series of manuals, of which the most recent edition is *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association, 1994), known as *DSM-IV*. *DSM-IV* contains diagnostic rules for all accepted psychiatric diagnoses and is divided into categories of mental illness, including organic mental disorders, anxiety disorders, personality disorders, and dissociative disorders. The dissociative disorders include dissociative amnesia, dissociative fugue, depersonalization disorder, dissociative identity disorder (multiple personality disorder), and dissociative disorder not otherwise specified (a category for other dissociative disorders that do not meet criteria for one of the defined conditions).

The *DSM-IV* diagnostic criteria for dissociative identity disorder (multiple personality disorder) are:

A The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B At least two of these identities or personality states recurrently take control of the person's behaviour.
C Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D The disturbance is not due to the direct effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

In *DSM-IV*, multiple personality disorder has been officially renamed 'dissociative identity disorder (MPD).' The rationale for this change was that it de-emphasized the erroneous concept of literally separate and distinct 'personalities,' substituting the less ideologically charged and more neutral term 'identities.'

In order to receive a diagnosis of MPD, one must meet each of the above criteria, which, in a clear-cut case, differentiate the disorder from other conditions at a high level of sensitivity. Skeptics about MPD claim that the criteria are vague and subjective, but evidence I review below indicates that MPD is actually a reliable and valid diagnosis.

The Clinical Logic of Multiple Personality Disorder

The basic logic of multiple personality disorder is a matter of common sense and is easy to understand. MPD is a chronic post-traumatic stress disorder of dissociative type with onset in childhood: it is a way of coping with overwhelming, chronic child abuse. Clinical experience has shown that complex MPD, with many different personality states and complicated amnesia barriers, simply does not occur in the absence of severe child abuse. In research series, about 95 per cent of cases of MPD can give you a child-abuse history at the time of initial interview (Ross et al., 1990), the remaining 5 per cent being either completely amnesic for their trauma or unwilling to disclose at that time.

A combination of physical, sexual, and emotional abuse is usually involved, along with a great deal of family violence, chaos, neglect, and inconsistency. (For instance, one patient I worked with had a personality created to handle the periods of several hours during which her mother

locked her between the back door and the screen door while she went shopping.) The sexual abuse usually starts before age five, lasts more than ten years, involves more than one perpetrator, and includes at least vaginal intercourse and fellatio. Often there will be a history of participation in child pornography, child prostitution, bestiality, and other highly deviant activities.

In research series, the ratio of female to male MPD patients is 9 to 1 (Putnam, 1989; Ross, 1989), but in studies screening clinical populations, such as general adult psychiatric in-patients or the general population, the ratio is usually 2 or 3 to 1. The fact that men with MPD do not get diagnosed and treated as often as do women is consistent with the tendency of women in our culture to seek mental-health services more often than do men.

A six-year-old boy or girl who is being sexually abused has no escape. The perpetrator often threatens the child with death, break-up of the family, death of siblings, being hated by God, intensified abuse, death of pets, or other calamities. These threats may be combined with calling the child 'Princess' and talking about the child's and the perpetrator's 'special secret.' One patient I worked with made a decision before age ten to make sure her father continued to focus his abuse on her when he came into the girls' bedroom at night, rather than going after her younger sisters. The conflict over this self-sacrifice was divided among several alter personalities, including one who felt dirty, one who was amnesic, one who thought the victim personality got what she asked for, and one who hated the sisters for never having to go through the abuse.

In such a situation, the child has no escape, except in the mind. A common dissociative strategy used by trauma victims is depersonalization, in which the person has an out-of-body experience and seems to float up to the ceiling or into the wall, or simply goes away into a fantasy world of dolls or to a magic garden. This pretending that the trauma isn't real is protective. Victims of airline disasters, muggings, or other single-episode traumatic events occurring in adulthood may experience such depersonalization states.

The child who is being abused repeatedly requires a more elaborate defensive strategy – what we call 'MPD.' The child performs two further basic manoeuvres: first, the little girl or boy imagines that the abuse is happening to someone else, so that now the child's primary identity is not just watching from outside the body but is actually watching another child being abused. Where would a child get the idea of transformation of identity, not having read a textbook on MPD? This is easy

to answer. The theme of the transformation of identity, to gain strength, protect oneself, or escape from danger, is universal in human cultures. It can be found in fairy tales, many mythologies and religions, and, in our culture, on Saturday-morning television, in books, in movies; in fact, it pervades the child's environment. Children in our culture are saturated with the concept of transformation of identity.

The next component in the creation of MPD is amnesia. Research shows that probably at least 50 per cent of children under age ten are highly hypnotizable, that is, are highly gifted at entering trance states, blocking out pain or memories, and becoming intensely absorbed in books, movies, or their play. Abused children use this ability to insert a memory barrier between themselves and the imagined new identity who is being abused. Thus, the abuse is not only not happening to the child, but he or she doesn't even remember it.

This process would not result in full, complex MPD if it was not continually reinforced by the abuse. With each subsequent episode of abuse, the new identity is reinforced and crystallized, until the child subjectively experiences the existence of an entirely separate person inside, of which he or she may be only partially aware. Of course, this separate identity is an illusion; however, for the defence mechanism to work, the illusion must be subjectively convincing to the child.

Over the years, different personality states may be created to handle non–trauma-related aspects of life through a process of generalization. The mind seems to adopt the habit of creating new identities to deal with school, friends, sports, and countless other aspects of daily living. This overutilization of dissociation eventually causes more problems than it solves: the person has no sense of continuity for his or her life and is missing a great deal of time owing to the amnesia barriers between the personality states.

Many of the signs and symptoms of MPD flow directly from the basic logic of the disorder – namely, dissociated personality states that take turns being in executive control of the body, combined with various kinds of amnesia barriers between the personality states. Most patients with MPD will report these symptoms occurring throughout their lives, and the key features of the disorder must be enquired about carefully and systematically.

First, there are blank spells, or periods of missing time. These occur when one of the other personality states for which the so-called host personality – the personality state that is in executive control most of the time – is amnesic is in executive control (this is called being 'out'). The

person may describe very sharply defined periods of missing time, for instance, complete amnesia for everything that occurred between 10:00 A.M. and 4:00 P.M. The person experiences a sudden return to consciousness, as though a switch had been thrown, at 4:00 P.M. and cannot remember a thing since morning.

The person may come out of a blank spell in a new location, unsure of how he or she got there. The person with MPD may come to in a bar, or in the company of strangers who appear to know him or her. Patients become skilful at handling these surprises without cueing anyone outside as to what is going on. People may tell them of things they've done which they don't remember, and complete strangers may seem to know them. Sometimes strangers will call the person by a different name. All these events are evidence of the activities of alter personalities for which the person giving the history is amnesic.

Patients with MPD frequently find objects unaccountably present or missing in their environment as well. This can happen to anyone, but a woman with MPD may open her closet and find three dresses she has never seen before, in a style she would never wear. Journals and diaries containing sensitive trauma-related material may go missing, then be found stuffed behind boxes in the basement.

The other major symptom is the hearing of voices. About one-third of MPD patients in large published series have been previously incorrectly diagnosed as schizophrenic by a psychiatrist who had not enquired systematically about MPD. This misdiagnosis is made because the psychiatrist concludes from the fact that the patient has been hearing voices for years that he or she must have schizophrenia. Actually, in MPD, the voices are those of the different alter personalities communicating with each other, and with the host personality.

The voices can take a variety of different forms, each of which is described in the schizophrenia literature with no reference to trauma or dissociation. The voices may talk to each other, or to the host personality, and they may command the host to do certain things. They may keep up a running commentary on the host's behaviour, or, less commonly, they can echo or anticipate the host's thoughts. A more detailed description of MPD voices is available in two of my texts (1989; 1994) and one by Frank Putnam (1989).

Numerous other symptoms are characteristic of MPD, and patients who experience them frequently meet *DSM-IV* criteria for many other disorders as well. In fact, in ongoing research on our Dissociative Disorders Unit at Charter Behavioral Health System of Dallas, we are learning

that the average patient we treat meets criteria for eleven different psychiatric disorders. This is actually quite easy to understand.

Consider a twenty-four-year-old woman with no prior trauma or mental-health problems who is raped by a stranger: she will develop an incomplete form of the polydiagnostic MPD trauma syndrome. Let's assume that this woman is in the top 10 per cent of the general population in hypnotizability (hypnotizability and dissociative capacity are closely interrelated). She uses her inborn dissociative capacity to block out all memory of the rape and therefore, by definition, meets *DSM-IV* criteria for dissociative amnesia disorder, which is psychologically based amnesia. This problem would not necessarily require treatment if everything went along fine, but, in cases coming for treatment, the amnesia works only partially.

This previously normal young woman starts having nightmares and insomnia. She feels inexplicably dirty, showers three times a day, and freezes if her sexual partner tries to initiate sexual contact with her. During the day, she experiences overwhelming waves of anxiety whenever she nears the location of the rape, so she starts avoiding that part of town, and she also becomes anxious and irritable around her male coworkers. All of these problems, combined with lack of sleep, reduce her energy level, she loses five pounds and starts to become demoralized and depressed. In order to sleep better, she starts drinking too much in the evenings.

Suddenly, this young woman, who is normally genetically endowed, meets or partially meets *DSM-IV* criteria for a dissociative disorder (dissociative amnesia), one or more anxiety disorders (obsessive-compulsive disorder [the showering]; panic disorder with limited phobic avoidance; post-traumatic stress disorder); a sleep disorder; substance abuse; one or more psychosexual disorders (impaired arousal and anorgasmia); and a mood disorder (depression). If this was a chronic pattern resulting from repeated childhood trauma, she would also receive a diagnosis of personality disorder.

It is by the same logic that people with MPD often simultaneously meet criteria for ten or more different diagnoses. They also receive additional diagnoses, such as schizo-affective disorder, schizophrenia, and bipolar mood disorder (manic-depressive illness), even though they don't actually suffer from those disorders, because of the rules of the diagnostic system.

In order to understand how to work clinically with MPD patients, one must also understand the central paradox of the disorder: much of the

'debate' about the reality of MPD is based on the failure to grasp this central logic.

The Central Paradox of Multiple Personality Disorder

Anyone who wants to understand, treat, or form an opinion on MPD must understand one central fact: people with MPD do not have more than one personality, they do not have other people inside; and, at least on my unit, they cannot evade responsibility for their actions because of amnesia. My view is that MPD is not grounds for diminished criminal responsibility. MPD is the most treatable major mental illness and is the only serious psychiatric disorder that can be rationally and scientifically cured within a strict medical-model approach. MPD is both real, in the sense that it is a serious illness, and not real, in the sense that there are not literally many different people living in the same body; therefore, debates about whether it is real or not are misconceived.

Rather than being an obscure curiosity, MPD is the paradigmatic example of the human response to chronic, severe childhood trauma. It affects about 1 per cent of the general population (Ross, 1991b) and at least 5 per cent of general adult psychiatric in-patients (Ross et al., 1991; Saxe et al., 1993).

As described above, the child *imagines* that the abuse is happening to someone else: this is a protective and defensive illusion, not an objective reality. But the illusion will not work unless it is subjectively compelling and believed by the individual. To be an effective illusion, MPD must be real – that is, an illusion with real, observable, measurable behavioural consequences. MPD patients aren't pretending that they can't remember what happened from 10:00 A.M. to 4:00 P.M.; they really can't remember. And they really do hear voices talking out loud inside their heads, voices which many psychiatrists cannot differentiate from those of schizophrenia.

To treat the disorder, one must enter into this imaginative reality and treat both sides of the paradox simultaneously. One has to empathize with the patient's inner world and work directly with the alter personalities *as if* they are separate people, while repeatedly defining explicitly for the patient that they are all parts of one person and need to be integrated. Concretely believing in everything as literally real will foster regression, dependency, evasion of adult responsibility, reinforcement of symptoms, and entrenchment in the sick role for secondary gain. Taking the opposite position of 'skepticism' results in a flight into health, rein-

forcement of the patient's denial, or loss of the patient from therapy. These same principles should govern the therapeutic approach to Satanic ritual abuse memories.

Professional Skepticism about Multiple Personality Disorder

The professional debate about the reality of MPD often consists of polarized extreme skeptics attacking straw-man believers they have set up at the opposite pole. For instance, in a debate about the reality of MPD I participated in at the Canadian Psychiatric Association Annual Meeting in Montreal, in September 1992, one of the psychiatrists on the other side said he was going to take an epidemiological approach and cited a number of general population surveys which found no cases of MPD. This would seem like a serious argument against the reality of MPD except for one fact: this psychiatrist didn't know that the standardized diagnostic interviews used in these studies do not enquire about dissociative symptoms or make diagnoses of dissociation.

The same psychiatrist reported the results of an informal mail-out survey he conducted in Ontario prior to the debate. He asked respondents if they had made a diagnosis of MPD, then used his data to back up his position that only a tiny minority of psychiatrists report cases of MPD. The problem here was that his own data refuted his argument: 38 per cent of the responding psychiatrists said that they had diagnosed a case. I pointed out that, had he mailed this questionnaire out ten years ago, the rate would have been under 5 per cent, and if he mailed it out ten years hence, the rate would likely be 90 per cent.

Someone in the audience objected to a point I had made and said I was incorrectly using the Dissociative Experiences Scale (DES) (Bernstein and Putnam, 1986) to make a diagnosis of MPD based on a high score. The critic's point was that the DES is a continuous measure yielding scores which range from zero to one hundred, and a cut-off score cannot be used to make a categorical diagnosis of MPD. Again, this would seem like a good point, but I pointed out that, less than five minutes earlier, I had reviewed data from a multicentre study involving 1,051 patients which showed that only 17 per cent of clinical subjects scoring above 30 on the DES had MPD (Carlson et al., 1993).

Another member of the audience objected that MPD enthusiasts think they have sole ownership of the sexual-abuse field and think that everyone who has been sexually abused has MPD. No one in the MPD field has ever made this claim. My reply was to cite a published paper of

mine (1991b) in which 20 per cent of individuals in the general population with a child-abuse history met criteria for one of the dissociative disorders, meaning that 80 per cent did not. These are the only data on this point in the literature, but neither the complainant from the audience nor the opponent taking an epidemiological approach had read the paper.

The extreme skeptical position about MPD has never been well argued in the professional literature and is always based on an inadequate knowledge of the scientific literature on dissociative disorders. Many psychiatrists still maintain a hostile attitude towards MPD and are derisive and dismissive of it. One of the motives for this professional resistance, I believe, is an ideological commitment to biomedical reductionism on the part of many psychiatrists; psychiatrists of this persuasion cannot accept the reality of MPD, or the pervasive role of childhood trauma in mental illness, because they are unwilling to undergo a paradigm shift to a trauma model of psychopathology, as I have argued in detail elsewhere (Ross and Pam, 1995).

The reason I describe this sociology of the psychiatric profession concerning MPD is that it lays the foundation for psychiatry's reaction to Satanic ritual abuse. The same polarized opinion, ignorance of the literature, and dichotomized extreme positions prevail in that debate as well.

The Difference between Structure and Content

Part of the problem with the debates about MPD and Satanic ritual abuse is a failure to differentiate between content and structure. For instance, it is generally accepted in contemporary psychiatry that the *content* of schizophrenic hallucinations varies around the world with culture, while the *structure* remains the same. This belief is based on the conviction that schizophrenia is a biomedical brain illness affecting about 1 per cent of individuals in all cultures. The culture affects the content, but the structure is based on hard brain chemistry and neurophysiology, according to this widespread viewpoint.

Having made this point about what they regard as *the* intrinsically psychiatric diagnosis, schizophrenia, MPD skeptics then go on to dismiss MPD as all fantasy and role-play: they fail to consider the structure–content distinction within MPD because such a consideration would force them to revise their thinking.

The structure of MPD is universal and is found in all, or nearly all, societies. The basic building-blocks of MPD are transformations of iden-

tity, in which some other entity takes executive control of the body; amnesia for the period of possession; trance states; and the hearing of voices. In North American culture, these universal features of human psychology are harnessed to cope with the endemic forms of chronic childhood trauma – namely, physical and sexual abuse. In a culture in which children were traumatized by war, famine, and hurricanes, we would expect to see chronic, complex dissociative disorders with different content but the same basic structure.

One of the key skeptical arguments is that MPD is culture-bound and occurs only in North America: this 'argument' could be refuted by a cultural anthropologist who took an interest in MPD or by someone with a basic, introductory knowledge of the field of dissociative disorders (Boon and Drajer, 1991). The same problem occurs in the polarized debate about the reality of Satanic ritual abuse. The *structural elements* of Satanic ritual abuse, as described earlier in this book, are present throughout human history, including the twentieth century. It would be a historical anomaly if there were no secret societies practising ritual human sacrifice in North America today.

In Part III, on therapy of Satanic ritual abuse survivors, I expand on the structure–content distinction and the need to work both sides of the central paradox at once.

The Scientific Literature on Multiple Personality Disorder

The scientific literature on MPD is small in quantity compared with that on the other major forms of mental disorders, but it is unsurpassed in methodological quality. A recent book, *Multiple Personalities, Multiple Disorders* (North et al., 1993), reviews the MPD literature in a comprehensive fashion, and the July 1993 issue of the *American Journal of Psychiatry* is in effect a special issue on dissociation and post-traumatic stress disorder, with nine articles and an editorial on these subjects. Additionally, the *Bulletin of the Menninger Clinic* 57/3 (Summer 1993) is devoted entirely to the diagnosis and treatment of dissociative disorders.

Washington University, whence *Multiple Personalities, Multiple Disorders* orginated, is a conservative, mainstream, and well-known centre of academic psychiatry, as is the Menninger Clinic. The serious, respectful treatment of MPD in these publications is a landmark in the history of the field.

The fact that MPD is the only major mental illness which can be treated within a strict medical model is paradoxical because many

extreme skeptics view themselves as biomedical in orientation, and consider MPD not to be a real disorder. To be a true disease within a biopsychosocial medical model, certain criteria must be met, and all of these are met by MPD. The diagnosis and treatment of MPD is analogous to the diagnosis and treatment of streptococcal pneumonia.

According to the biomedical model, one must, first, know the etiology of the disease. Although we do not understand the basic neurophysiological mechanisms of dissociation or any other higher brain function, this does not matter for treatment. The cause of MPD, simplified, is the dissociative response to severe, chronic childhood trauma. The trauma is like the germ in pneumonia, without which the illness would not occur. Critics sometimes object that this is an oversimplified unidimensional causal model of MPD, but that is not so; pneumonia would not occur without germs, but it also requires the existence of lungs and an immune system. Pneumonia is the end-result of a complex interaction of host- and infectious-agent factors, as is MPD.

Second, we can make a micro-detailed analysis of the relationship between etiology and phenomenology in MPD. We can relate numerous symptoms back to specific events, cognitive conflicts, cultural influences, and other highly specified factors. For instance, in our culture an abused girl might create a John Rambo alter personality as a protector but would not create a female pearl-diver personality for this purpose. This is analogous to a detailed understanding of how the streptococcus gets into the lungs, and how the lungs and immune system react to it, creating the symptoms of pneumonia.

The characteristic signs and symptoms of the disorder must be organized into a differential diagnostic decision tree, which results in ruling in MPD and ruling out other possible diagnoses at high levels of reliability and validity. This diagnostic methodology is in place.

The third step is a micro-detailed series of connections between phenomenology and the specifics of treatment: we can relate what we do in MPD therapy to a detailed understanding of the symptoms, and their origins in the child abuse. This is analogous to what is called 'rational' treatment in medicine, which means treatment based on an understanding of the mechanisms of both the disease and the treatment. For streptococcal pneumonia, we know precisely how penicillin attacks the cell wall of the bacterium, killing it. Finally, this medically and scientifically rational treatment based on an understanding of the underlying mechanisms of the disorder, must result in cure, which it can in both MPD and streptococcal pneumonia.

This line of reasoning does not imply that MPD is a biomedical disease like bacterial pneumonia: the logic of the argument holds *structurally* but at a psychosocial level. MPD is not a biomedical disease but a psychiatric disorder: it is the only major mental illness for which each of these logical steps has been filled in to an extent that permits cure.

How is a disorder shown to be valid and reliable in psychiatry? The basic procedure is quite straightforward. Operationalized diagnostic criteria for the disorder are defined, standardized interviews for making the diagnosis are developed, and the reliability of the diagnosis is then studied. Such reliability studies can take several forms, but two common ones are to test interrater reliability and the level of clinician-structured interview agreement. The statistic for analysing such data is called 'Cohen's *kappa*,' with perfect agreement generating a score of 1.0.

In testing interrater reliability, a pool of subjects, some with the diagnosis and some without, are interviewed separately by two different interviewers, neither of whom knows the results of the other interviews or the subjects' clinical diagnoses. If the two interviewers agree perfectly on who does have the diagnosis and who does not, *kappa* is 1.0. Similarly, *kappa* can be calculated for the level of agreement between the structured interviewer and a clinician making the diagnosis by clinical interview. In psychiatry, the clinical diagnosis is the gold standard against which all comparisons are made, and this is an accepted reality for all other disorders.

The average *kappa* value for the Structured Clinical Interview for *DSM-III-R*, one of the most widely used structured interviews in psychiatry, is 0.68 across a wide range of psychiatric diagnoses. The highest *kappa* for any single diagnosis is 0.92, for panic disorder. There are two structured interviews for making dissociative disorder diagnoses, the Dissociative Disorders Interview Schedule, which I developed (Ross, 1989), and the Structured Clinical Interview for *DSM-III-R* Dissociative Disorders (Steinberg, Rounsaville, and Cicchetti, 1990), developed by Marlene Steinberg. Although a greater quantity of data needs to be collected, both these structured interviews have *kappa* values in the range of 0.95 to 0.96. MPD can be diagnosed with a higher level of reliability than can any of the other major mental disorders. There are several self-report measures of dissociation available which are as scientifically robust as any measure of any form of psychopathology, though again the quantity of data is comparatively small (Carlson et al., 1993).

Validity is a more difficult property to demonstrate, and there is much more controversy about how to demonstrate it. However, clinically the

most important form is treatment validity: does the diagnosis, reliably made, lead to a significant improvement in clinical outcome? Although we lack definitive, funded, large-scale treatment-outcome studies, the answer to this question for MPD is an unequivocal 'Yes.' Diagnosing and treating MPD could well be the most cost-effective mental-health intervention known, though more research is required to establish that this is so.

Preliminary data gathered in Winnipeg (Ross and Dua, 1993) indicate that reducing the average time an MPD patient spends in the mental-health care system prior to the MPD being diagnosed from an average of seven or eight years, as is currently the case, and, instead, instituting specific treatment after one year will result in psychiatric health-care savings in the order of $250,000 per case. These are preliminary data and require replication, but they are consistent with the treatment outcomes observed throughout North America. People with MPD who have been mired in the psychiatric health-care system for years, receiving numerous different diagnoses, drugs, and treatments, and showing no substantial improvement, can make a remarkable recovery. This is not surprising, since the treatment is based on understanding the etiology and phenomenology in detail, and instituting a medically rational treatment plan which directly addresses the basic psychosocial mechanisms of the disorder.

If you assume that what I am saying is correct, it becomes a puzzle why psychiatry is so opposed to the concept of MPD. I address this question below, and in more detail in chapter 11. The main point to remember is that professional skepticism about Satanic ritual abuse, like that about MPD, is often based on preconceived ideology, attitudes, personal opinions, and beliefs, not on knowledge of the relevant literature or careful thinking about the issues. The skeptical opinion of the psychiatrist who says that Satanic ritual abuse is all hysteria does not necessarily carry any weight because this is not a conclusion reached through careful study and thought but is only a preconception. The same holds for the 'believer' who considers every memory of every survivor to be historically accurate. That, too, is merely a preconception, albeit at the opposite pole.

Psychiatric Resistance to the Reality of Non-Ritual Child Sexual Abuse

To have a complete context for the discussion of Satanic ritual abuse, one

must understand psychiatry's failure, in the 1980s and into the 1990s, to acknowledge the reality and effects of non-ritual childhood trauma. In the 1980 edition of Kaplan, Freedman, and Sadock's *Comprehensive Textbook of Psychiatry*, which comprises 3,365 small-print double-column pages, there is a section, pages 1653–1811, called 'Normal Human Sexuality and Psychosexual Disorders'; it contains fifteen subsections, the last of which is called 'Special Areas of Interest,' occupying a total of eight pages.

The subject headings within 'Special Areas of Interest' include 'Rape' (two pages), 'Spouse Abuse' (one page), 'Incest' (two pages), 'Infertility' (one page), 'Sterilization' (one page), and 'The Unconsummated Marriage' (one page). In the section on incest, there is one paragraph on the epidemiology of incest, which includes citation of a 1955 article estimating that incest affects one family out of a million in North America. Additionally, there is a statement that incest occurs much more often in families of low socio-economic status. I mention a 1980 psychiatry text here because it was the major text on which my training was based, and because denial of the extent and impact of incest is still in place in North American psychiatry in 1995, although no psychiatrist can dispute that incest is 10,000 times more common than the estimate of one family out of a million.

For instance, in a paper by Mary Rotheram-Borus entitled 'Suicidal Behavior and Risk Factors Among Runaway Youths' in the January 1993 issue of the *American Journal of Psychiatry*, not a single reference is made to childhood trauma or physical or sexual abuse. In a long list of events precipitating the suicide attempts, the author notes that 4 per cent of the children reported being sexually abused immediately prior to attempting suicide, but there is no further discussion of this, and no discussion of child abuse as a major factor in either the running away or the self-destructive behaviour.

In a comprehensive review article by Natalie Grizenko and Christina Fisher, in the December 1992 issue of the *Canadian Journal of Psychiatry*, entitled 'Review of Studies of Risk and Protective Factors for Psychopathology in Children,' there are no references to research on childhood trauma, except for brief mention of one paper studying protective factors in abused children. Yet the authors devote two long paragraphs to the importance and implications of chromosomal abnormalities for their review.

These papers demonstrate the socialization against serious consideration of childhood trauma active in psychiatry up to the present, com-

bined with socialization to overemphasize genetic factors (Ross and Pam, 1995). Nearly every issue of the *American Journal of Psychiatry* contains at least one paper that is methodologically flawed by its failure to consider childhood trauma, and this journal, more than most, is open to trauma-related research. A pervasive, institutionalized denial of the importance of childhood trauma has dominated North American psychiatry throughout the twentieth century.

Besides this institutionalized denial, we know from seven or eight published studies that 10 per cent of psychiatrists, physicians of all kinds, social workers, and psychologists will admit in an anonymous survey to having had sex with a patient or client. This means that at least 10 per cent of psychiatrists are inclined to minimize the reality and effects of sexual abuse in order to maintain their denial about the effects of their own perpetration.

Further, the percentage of mental-health professionals who are trying to suppress their own trauma histories and not deal with them is unknown. At one of the two major annual MPD meetings in North America, held in Alexandria, Virginia, in June 1992, Barry Cohen, Joan Turkus, Christine Courtois, and I found that, out of 379 professional registrants completing a survey, 55 per cent reported a history of childhood sexual abuse. These professionals are at risk for projecting their denial of their own trauma onto their patients and also for overidentifying with their patients, and becoming uncritical 'believers.'

Finally, some mental-health professionals believe dogmatically what they were taught by their instructor and do not learn anything fundamentally new once they are five years out of training. Like most people, the majority of mental-health professionals will remain committed to the dying paradigm during a period of paradigm shift. A paradigm shift from reductionist, endogenous models of mental illness to a trauma-based model is under way in the mental-health field, with the resistance by bioreductionist psychiatry getting more entrenched as the evidence supporting the new paradigm accumulates. The resistance often takes the form of denial and silence, and is focused on multiple personality disorder, as I discuss in more detail elsewhere (Ross and Pam, 1995).

It is essential to understand the performance of academic psychiatry over the previous hundred years concerning severe childhood trauma in order to have a context for assessing skeptical reactions to Satanic ritual abuse. If multigenerational orthodox Satanic cults actually exist in North America, and patient memories of them are accurate, at least in part, the expected response of mainstream psychiatry, at least initially, will be to

deny the reality of the trauma and to discredit the survivors and their therapists.

Multiple Personality Disorder and Satanic Ritual Abuse

The relationship between MPD and ritual abuse should be apparent at this point: MPD is a dissociative strategy for coping with overwhelming trauma, and since ritual abuse is one of the most devastating forms of trauma a child can experience, it is to be expected that many survivors of such abuse will have MPD.

On the other side of the equation, people with MPD have the most fragmented memories of anyone in our culture, and since they are highly hypnotizable, they are highly suggestible; this means that they must *inevitably* experience significant contamination of their memories from cultural sources, therapist expectations, and the media. Contamination of the MPD field with pseudo-memories of ritual abuse is unavoidable.

The undeniable fact of false memories does not discredit either MPD or Satanic ritual abuse as a real phenomenon, however, as long as one avoids dichotomized, black-and-white, all-or-nothing thinking. It is important to remember the content–structure distinction: the component of hypnotizability which gives rise to the *structure* of MPD is focused attention: suggestibility gives rise to *content*. Contamination at the level of content is a minor problem, and one doesn't really treat the content in any case, as I explain in chapters 8–10. This is also true for the behavioural desensitization of simple phobias, in which the content of the phobia is of limited relevance to the structure and principles of the treatment plan.

Conclusions

The purpose of the chapter has been to define multiple personality disorder, explain its clinical logic, and briefly review its scientific status. One cannot understand Satanic ritual abuse without understanding complex dissociation and its relationship with trauma. Additionally, I have briefly reviewed the nature of the dichotomized debate about MPD within psychiatry to set a context for discussion of Satanic ritual abuse, which tends to occur in the same polarized format.

Opinions about Satanic ritual abuse, expressed by highly skeptical mental-health professionals, sociologists, and other professionals often

carry little real weight because they are based on preconceived ideological positions and lack of knowlege of the relevant literature, intellectual rigor, and often direct experience with the psychotherapy of ritual abuse survivors. The polarized skeptic represents the extreme pole of the hypnotic logic and has pulled so far out into 'objective reality' that he or she sees no reality at all.

The believer, by contrast, has been fully absorbed into the hypnotic inner reality of the client and uncritically considers everything to have concrete and literal reality: this is a hypnotic suspension of critical faculties. The believer has also lost reality, but in the opposite direction. It is surprising how many people actually represent these two extreme poles in fairly pure form, and I am dismayed at how few participants in the 'debate' achieve a balanced middle ground.

7

Alternative Hypotheses of Ritual Abuse

Ritual abuse is a perplexing clinical problem within the dissociative-disorders field (Gray, 1992; Sakheim and Devine, 1992). The cults described by patients are often Satanic (Feldman, 1993; Marron, 1988; Mayer, 1991; Nurcombe and Unutzer, 1991; Ryder, 1992; Smith and Pazder, 1980; Spencer, 1989; Warnke, 1972) but can take many forms, including right-wing survivalist and New Age. The purpose of this chapter is to review alternative hypotheses of Satanic ritual abuse, an essential aspect of any balanced consideration of the problem. Therapists need to be aware of these alternative hypotheses in order not to be drawn too far into the hypnotic inner reality of their clients.

What is it that alternative hypotheses of ritual abuse must explain? There are so many forms of ritualized abuse being remembered by survivors in the 1990s that no one hypothesis is likely to encompass all of them. For instance, ritualized group sexual practices by child pornographers might properly be called ritual abuse, and might lead to convictions and physical evidence in the form of photographs and videos, but such activities do not constitute multigenerational orthodox Satanic ritual abuse.

The controversy about Satanism is focused on the reality of survivor memories of childhood and ongoing involvement in sophisticated, organized, widespread, secret cults. The memories are experienced as actual historical events personally remembered, with full visual, affective, autonomic, and cognitive components. Survivors are recalling, not just ritual abuse in the remote past, but ongoing accessing by cult members, activation of mind-control programs through specific cues and triggers, cult surveillance, and ongoing participation in cult rituals.

In discussing alternative hypotheses to Satanic ritual abuse, I am mak-

ing the assumption that they are alternatives to the hypothesis that the memories are historically accurate and real. None of the alternative hypotheses can account fully for the memories of Satanic ritual abuse survivors; however, each of the hypotheses, when advanced in a reasonable fashion, contributes something to our overall understanding.

Urban Legend and Rumour Panic

The basic problem with the 'mass hysteria' set of explanations for ritual abuse (Victor, 1990; 1993) is that they were devised to explain the transmission of *third-party* stories of Satanic ritual abuse and are based on the phenomenon of urban legend, which does not encompass first-person reports (Brunvand, 1981). When this is what is going on, the analysis can be completely convincing, as in the chapter by Robert Balch and Margaret Gilliam in *The Satanism Scare* (Richardson, Best, and Bromley, 1991). Balch and Gilliam analyse in detail how a rumour of Satanic ritual abuse in Montana originated, how it was perpetuated, and how it persists despite objective evidence that the original events could be accounted for entirely on the basis of the criminal activity of single individuals.

There is no doubt that rumour panic about Satanic cults is widespread in North America. A mass-hysterical reaction to Satanic urban legends could be destructive and dangerous and could potentially escalate well beyond the level of McCarthyism within the next ten years. Several books written from a Christian-fundamentalist perspective advocate book-burning, rigid restriction of school curricula, and other repressive measures based on the threat of Satan (Brown, 1987; Bubeck, 1991; Larson, 1989; Passantino and Passantino, 1991): these authors use Satanic rumour panic as fuel for their political–religious agenda (Mulhern, 1994).

As an explanatory mechanism, rumour panic accounts for only one aspect of the phenomenon and does not touch on the problem of the creation of false personal memories. If one views multigenerational orthodox Satanic ritual abuse as solely an urban legend, it would be advisable to take Brunvand's (1981) approach to folklore stories into account. He points out the impossibility of ever finding the initial source for an urban legend, an error made by Jeffrey Victor (1993, p. 81) when he cites *Michelle Remembers* (Smith and Pazder, 1980) as the oldest known Satanic cult survivor story, failing to mention *The Satan Seller* (Warnke, 1972), which came out eight years earlier.

Additional evidence that the urban legend of Satanism was well

established prior to the appearance of *Michelle Remembers* is given by Brunvand (1981, p. 90), who states that an urban legend about McDonald's diverting profits to a Satanic cult was current in 1977. If Satanic ritual abuse is predominantly or entirely an urban legend, one should bear in mind that we are all prone to believing and transmitting urban legends; the fact that the Satanic legend was perpetuated by a combination of fundamentalists, tabloid journalists, therapists, and patients does not necessarily mean that these people are more 'hysterical' than those who believe in the vanishing hitchhiker, the hippie babysitter who cooked the baby, or alligators in New York sewers. The themes of the Satanic urban legend, including infant sacrifice, the supernatural, illicit sex, and cannibalism of animals, are all present in the urban legends recorded by Brunvand.

The Patients Are Psychotic or Delusional

Even cursory exposure to dissociative-disorder patients reveals that they are not grossly psychotic and do not have thought disorders. However, clinically, many could have grandiose delusional disorders of the persecutory type. If one assumes that the memories are not real, this is by definition the case. However, delusional disorders as defined in *DSM-IV* (American Psychiatric Association, 1994) and the contemporary psychiatric literature do not involve fully formed memories; they are supposed to be cognitive in nature and involve incorrect inferences and fixed false beliefs. Concluding that patients with Satanic ritual abuse memories are delusional does not account fully for the phenomenon because the memories appear clinically to be fully formed, detailed narratives, accompanied by autonomic hyperarousal.

Another problem is that the delusions of Satanic human sacrifices do not meet strict criteria for delusions because they are consistent with the beliefs of a substantial subculture, and therefore are technically not delusional for the same reason that the beliefs of non-destructive religious groups are not.

On the other hand, many Satanic ritual abuse patients exhibit thought patterns that are similar to those of frankly delusional patients who have well-encapsulated delusional systems. The ritual patients tend to build up strongly held conclusions about ongoing surveillance and accessing from extremely flimsy evidence, and their cognitive structures tend to become increasingly elaborate as they feed on themselves. Additionally, the beliefs often become impervious to counterevidence or -argument.

The criteria for 'validation' of Satanic ritual abuse memories often become extremely loose, consisting of another patient sharing the same feeling or also having drawn the same symbol in art therapy. These 'proofs' are similar in nature to those offered by delusional patients. The paranoid quality of seeing cult infiltrators everywhere may become malignant and may directly affect behaviour in a way which is unhealthy, even if the ritual abuse and mind control actually happened. Overall, the clinical phenomena are more closely related to delusional disorders than to rumour panic or urban legends.

A complex dissociative delusional system enlarged to the level of a subculture myth seems to me the most likely alternative hypothesis. Every professional working in the dissociative-disorders field has been incorporated into some patient's delusional system as being cult-involved, myself included.

Satanic Ritual Abuse as a Form of Münchausen's Syndrome

Münchausen's Syndrome, officially called 'factitious disorder' in *DSM-IV*, is a disorder in which people seek extensive treatment for problems – medical or psychiatric – they do not have. The patients fabricate elaborate accounts of different symptoms and may deliberately induce symptoms in various ways, such as injecting themselves with faeces. Medical–surgical Münchausen's cases may receive many different surgeries, invasive tests, scans, and hospital admissions (Feldman and Ford, 1994). The purpose of the behaviour is thought to be the gain received from being in the patient role.

An alternative hypothesis is that the memories of Satanic ritual abuse are best understood as a psychiatric Münchausen's Syndrome. When false-memory suits occur following recantation of the memories, the accounts of what happened in therapy are likely to be as fantastic as the initial ritual abuse memories, but in the current political and legal climate, the false memories of therapy will be heavily reinforced by the secondary gain of successful legal action. According to this hypothesis, reinforcing the false memory that the ritual abuse was implanted by the therapist in turn reinforces the Münchausen's Syndrome, by legitimizing a fantastic account of therapy.

A patient I treated recently had a classical history of medical–surgical Münchausen's and claimed to have survived driving off a 700-foot cliff by virtue of the extra padding in her car seat. She began to absorb Satanic ritual abuse memories very quickly on our Dissociative Disor-

ders Unit, having been referred to us for multiple personality disorder, which she did not have. This problem was dealt with by telling her directly that she had Münchausen's Syndrome and working with her on real psychotherapeutic issues.

The problem with the Münchausen's hypothesis is that the behaviour of Satanic ritual abuse survivors does not seem to be consciously intentional, as required by *DSM-IV* criteria. Also, it is reinforced by secondary gain in the current legal climate, which pushes the phenomenon in the direction of malingering. Additionally, it is unclear whether the symptoms are better accounted for by another disorder. Nevertheless, Satanic ritual abuse memories often have the fantastic quality of full Münchausen's Syndrome.

Histrionic Behaviour Secondary to Contamination by Books and Movies

The main problem with the 'histrionic behaviour' hypothesis, like the other alternatives, is that it is unitary and simplistic, while the phenomena are complex and heterogeneous. When advanced as a sole and complete explanation, 'hysteria' is a vague and inadequate construct. However, it is surely an operative element.

It was recognized in the Middle Ages that the spread of an epidemic of demon possession could be prevented by quarantining the first case in a town. This principle applies in the twentieth century as well. To complicate matters, however, secondary gain and hysteria can occur as reactions to real events, real sociological problems, and real biomedical diseases, so the presence of these elements does not necessarily weigh in favour of Satanic ritual abuse's being entirely unreal.

Ritual abuse cases need to be managed in such a way that hysteria, regression, grandiosity, and secondary gain are discouraged rather than fostered. However, it must also be remembered that 'hysteria' and 'attention seeking' explanations generally function as justifications for not thinking about the complexities of the clinical problem.

The media-contamination hypothesis usually focuses on the book *Michelle Remembers* (Smith and Pazder, 1980) and the movie *Rosemary's Baby*; however, a Satanic ritual mass involving sex and cannibalism in symbolically transmuted form occurs in Walt Disney's *Fantasia*, which has a copyright date of 1940. These images were in the popular culture for centuries before survivor memories started to surface in therapy; therefore, the media-contamination hypothesis

fails to account for the time lag and cannot provide a full account of the phenomenon.

Contamination by Therapists

The problem with the 'contamination by therapists' hypothesis is that, when advanced, it is often overgeneralized as justifying dismissal of the entire phenomenon. I have observed clear examples of contamination by therapists and the media. However, I have also met many patients who divulge detailed, clear information about specific symbols, mind-control techniques, and settings which I have never encountered in print, heard of before, or imagined myself. This occurs so consistently and pervasively in the field that therapist contamination cannot account for all patient productions.

A more viable hypothesis would combine contamination at a more global, cultural level with idiosyncratic confabulation of detail by the individual unconscious. However, this hypothesis begs the question of how the 'unconscious' actually accomplishes this task. Further, it does not account for the widespread clinical observation that patients who have never met report similar minute details. A more likely source of significant contamination is other patients, who are well connected by telephone, newsletters, computer bulletin boards, gossip, and group therapy in a national-level network through which specific details about Satanism can be transmitted at high speed.

Drug Hallucinations

Those who believe in the reality of Satanic ritual abuse advance the argument that impossible memories are the result of a mixture of drug hallucinations, staged events, and false memories deliberately implanted by abuse perpetrators. This argument illustrates the fact that any clinical observation or hypothesis can be modified to either support or refute the reality of ritual abuse.

I have encountered cases in which it appears clear that the patient hallucinated much of the false memory. In such cases, the patient remembers taking the drug or the onset of a drug-induced state and has an insoluble subjective problem: it is impossible to sort out what did or did not happen. In the same patient, however, other ritual abuse memories may be resolved into what appear to be clear historical recollections, and the associated traumatic symptoms may be treated to stable resolution.

Clinically, drug-induced hallucinations and apparently real memories are sometimes not difficult to differentiate. For instance, one patient remembered having her head cut off in a ritual; although she realized this was impossible, she experienced the memory as a subjectively compelling historical fact. Drug-induced distortions of perception, especially during childhood, introduce a further element of confusion into both the clinical work and the professional controversy about the reality of ritual abuse.

An analogous source of uncertainty is the fact that many rapes, traffic accidents, assaults, and other events occur when one or both parties' recollections are distorted by drugs and/or alcohol. This troublesome distortion is never used as an argument against the reality of rapes occurring in North America or alcohol-related motor vehicle fatalities; therefore, drug distortions are not, in and of themselves, evidence or argument against the reality of Satanic ritual abuse.

Hysteria Fanned by Christian Fundamentalists

The alternative hypothesis that identifies hysteria promoted by Christian fundamentalists can be supported by published writings, the behaviour of radio and television evangelists, and much other publicly verifiable information (Brown, 1987; Bubeck, 1991; Larson, 1989; Passantino and Passantino, 1991). In the cosmic battle against Satan, it is essential that Satan actually present himself on earth for combat; otherwise, the danger will not be tangible, and donations of faith, support, money, and allegiance will not be so readily forthcoming.

I have had a number of clinical encounters with MPD patients who have undergone exorcisms by Christian fundamentalists. Selection bias prevents my seeing successful outcomes of exorcism, if they exist; however, in my clinical experience, the investment of the exorcist is in ideology, not in the patient's welfare. The exorcism of the so-called demons destroys the treatment alliance with the legitimately angry alter personalities, reinforces the patient's dissociation, undermines his or her function, and often results in hospitalization.

The potential for extreme fundamentalist Christianity to shift into suppression of civil liberties in North America, with witch hunts and persecutions, is much more than theoretical. Such elements within contemporary Christianity are heavily invested in the reality of Satanic ritual abuse and its threat to the family. Extreme Christian-fundamentalist zeal about fighting Satan contributes to hysteria about ritual abuse and

amplifies the phenomenon far out of proportion in terms of possible real organized Satanic activity. I have heard estimates of 50,000 babies being sacrificed per year by Satanists in North America, which is simply not possible.

Isolated Psychopaths

Another hypothesis is that isolated psychopaths account for all the serious Satanic crime in North America. An example of this kind of criminal discussed in a previous chapter is Richard Ramirez, the Midnight Stalker, who conducted serial murders in California in the 1980s. Other examples of teenagers and young adults who committed murders are referred to in a variety of books on Satanism (Johnston, 1989; Larson, 1989; Lyon, 1988; Raschke, 1990), but there is no evidence that any of these individuals were part of any extensive organization. Nor is there any evidence that their crimes were religious or spiritual in motivation: most can be readily accounted for by child abuse, parental neglect, drug involvement, and mainstream psychiatric diagnoses, and have everyday criminal motives.

The problem is that the existence of documented isolated psychopaths is sometimes regarded as evidence against the reality of ritual abuse. This is logically equivalent to arguing that the conviction of lone bank robbers motivated by heroin addiction is evidence against the existence of organized crime. Such arguments are transparently erroneous.

Satanism Is a Cover for Organized Crime

There is insufficient evidence to make any real judgment about the hypothesis that Satan is a 'cover' for organized crime. The ritual murders conducted by Mexican drug runners in Matamoros would appear to be an example of this phenomenon, though the murderers apparently actually believed that their sacrifices would protect them from police bullets. According to Raschke (1990), belief in and practice of Satanism is so widespread among Hispanic-American drug runners in southern Texas that locals have a special term for these people, 'Narcosatanistos,' as mentioned previously. To simply describe Satanism as a *cover* for such crime is to oversimplify, since the Satanism appears to be interwoven with a variety of behaviours in a complex fashion. Nevertheless, it is probably true that the usual motivations of organized mid-level drug dealers predominated among the Matamoros murderers, with Satanic magico-religious beliefs being secondary.

Another oversimplification illustrated by the Matamoros case is that the 'Satanism' was actually a self-styled conglomerate of Palo Mayombe, Santería (two folk cults based on a synthesis of Catholicism and African tribal religions), and other influences; therefore, calling it 'Satanism' is näive from an ethnographic point of view. The argument that 'Satanism' is a cover for organized crime is flawed because there is no unitary construct of 'Satanism' to act as a cover, and because the relationship between a primary and a cover operation in organized crime is more complex than the 'cover' hypothesis of ritual abuse implies.

The major type of crime mistaken for multigenerational orthodox Satanic ritual abuse is probably pornography operations using Satanic sets and themes. I worked with a female patient who, early in therapy, switched to a male past-life alter personality who believed he had perished in a Nazi death camp: later in therapy, it appeared that the patient had been involved in hard-core pornography as a child, including films in which the adult actors dressed up as Nazi doctors and nurses and called the patient by a male name. This patient also described participating in other pornography films which involved no unusual sets or themes. Whether the pornographic memories were real or false in this case, I could not tell, but they illustrated the possibility that some memories of Satanic ritual abuse may be attributable to actual participation in child-pornography films with Satanic props.

An Age-Old Cultural Myth and Superstitious Fears

This hypothesis is advanced in two forms. In the first, a straightforward explanation is offered that there have always been monsters and boogeymen in the human psyche: the Satanists are simply the boogeymen of the 1980s and 1990s. This hypothesis is attractive because it is unpretentious, and undoubtedly contains an element of truth.

As is true of the urban-legend hypothesis, however, the boogeyman myth does not account for the phenomenon of personally remembered historical narratives with a full range of congruent cognition, visual image, emotion, and physiological arousal. The boogeyman myth simply does not address the psychological mechanisms which would have to underlie Satanic false memories, and it fails to acknowledge the profound implications of such widespread confabulation.

A pseudo-sophisticated version of this hypothesis is the proposition that Satanic 'memories' originate in the collective unconscious, where they are stored in a video library of horror. This hypothesis can be nei-

ther proven nor refuted; therefore, there is no real comment to make about it.

Conclusion

Ritual abuse is a complex and perplexing phenomenon, and we simply do not know what percentage of survivor memories are real. Given the history of man's barbarity, and the large-scale atrocities committed by all races in the twentieth century, it is important that we not adopt the role of good Germans who looked the other way while the Nazis carried out their human sacrifices. It is equally important not to foster a hysterical witch hunt. Satanic ritual abuse should be a subject of dispassionate intellectual and scientific enquiry and serious law-enforcement investigation. We should expect to discover a complex, heterogeneous, and fluctuating combination of fact, fantasy, and fiction as we learn more, and we should not endorse any one hypothesis prematurely, to the exclusion of others.

Therapists treating Satanic ritual abuse survivors need to consider the alternative hypotheses described in this chapter in order not to be pulled too far into their clients' inner hypnotic reality.

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III
Therapy of Satanic Ritual Abuse Survivors

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8

How to Recognize Satanic Ritual Abuse Survivors

The purpose of this chapter is to describe individuals who will recover Satanic ritual abuse memories in therapy, whether those memories are real or not. I am not going to debate whether the material in this chapter is likely to stimulate the *recognition* or the *creation* of Satanic memories. My intention is to provide both a method for approaching the problem clinically and a clinical context for debate and discussion. To date no one has published a detailed and adequate account of how Satanic ritual abuse memories are detected by clinicians; therefore, an essential aspect of the context for informed discussion has been missing. I will deal only with ritual abuse survivors who have multiple personality disorder, since my clinical experience is limited almost entirely to this population.

Before considering signs and symptoms specific for Satanic ritual abuse, it is necessary to set a wider context; therefore, I will discuss the general signs and symptoms of childhood sexual abuse, the psychodynamics of childhood sexual abuse, and the manifestation of these dynamics in multiple personalty disorder, and then detail the signs and symptoms of Satanic ritual abuse.

The debate about Satanic ritual abuse is often skewed by mistaken and uninformed allegations concerning procedures and practices within the field of dissociative disorders. I do not discuss errors and improper procedures, which occur in all areas of psychiatry, but instead outline what I consider to be the correct way to understand and study the internal structure of Satanic ritual abuse cases.

General Signs and Symptoms of Childhood Sexual Abuse

There is a large literature on childhood sexual abuse. For readers not

familiar with this material, I recommend books by Herman (1992), Fredrickson (1992), Bagley and King (1990), Courtois (1988), Briere (1989), Rush (1980), and Goodwin (1989), which provide both a comprehensive understanding of the subject and an entry point into other key references. Two journals to which I have contributed, and which I recommend, are *Child Abuse and Neglect* and the *Journal of Child Sexual Abuse* (I am on the editorial board of the latter).

Although data vary from study to study, Bagley and King (1990) summarize the epidemiological literature on childhood sexual abuse by concluding that a minimum of 5 per cent of boys and 15 per cent of girls experience unwanted sexual abuse by persons at least five years older than themselves before age eighteen in North America. It appears that about 2 per cent of girls in North America are sexually abused by their biological fathers before age eighteen, while 17 per cent of girls with step-fathers are sexually abused by them (Bagley and King, 1990).

The accepted figure for the proportion of false allegations of childhood sexual abuse is about 5 per cent of the total and most of these occur in contexts with clear secondary gains, such as child-custody disputes (Goodwin, Sahd, and Rada, 1989). When systematic attempts are made to verify abuse allegations through irrefutable physical evidence, perpetrator confession, or corroboration by eyewitnesses, it appears that as many as 80 per cent of allegations can be substantiated (Bagley and King, 1990), though this area requires much more study: in the one study attempting to corroborate sexual abuse histories of twenty MPD patients, Coons (1986) was able to obtain independent verification of the memories in 85 per cent of cases.

Studies of clinical populations suggest that probably at least 50 per cent of general adult psychiatric in-patients have been sexually abused in childhood, while the figure for certain diagnoses like borderline personality disorder is probably in the range of 60–80 per cent. Childhood sexual abuse affects all socio-economic strata, religious groups, and geographical areas, and sexual abuse by clergy, psychotherapists, teachers, day-care workers, and others in positions of trust and authority is common. Although I have not done a tabulation, many of the women admitted to our Dissociative Disorders Unit have been sexually victimized by therapists or doctors. I have encountered allegations against professionals by MPD patients which I considered to be confabulated, but the majority of accusations seem genuine, in the absence of definitive evidence one way or the other, and in a number of cases the therapist has confessed to sexual involvement.

The long-term signs and symptoms of childhood sexual abuse span the entire *DSM-IV*. Severe childhood trauma, according to the model of mental illness I favour (Ross, 1989; Ross and Pam, 1995), is a major and pervasive theme in the mental-health field and, from a public-health point of view, a major driver of serious psychopathology. In the most general sense, then, the long-term consequences of childhood trauma can be any of the symptoms described in *DSM-IV*. Additionally, serious child abuse affects long-term physical health, ability to function in the workplace, personal relationships, and spiritual life.

Simplistically, but for convenience, adult survivors of childhood sexual abuse can be divided into two groups – those with easily recognizable problems related directly back to their childhoods and those who are able to maintain an intact functional surface occupationally and socially but are impaired in their private personal lives. The important thing to understand is that victims of severe childhood trauma can appear well adjusted in a casual encounter, or in the workplace, despite serious ongoing personal problems. It is equally true that many people overcome their pasts, recover, and do well.

An example of an individual with a child abuse history acting out in a highly deviant fashion is Roch Theriault, a French-Canadian leader of a small cult currently serving a jail term for amputating a cult member's right arm, murder of another cult member, and related acts such as surgical removal of a cult member's testicle followed by cauterization with a section of truck drive shaft. Theriault's activities included orgies; drunken violence; polygamy; sexual abuse of children; and having a murder victim's corpse dug up, the uterus removed, and the top of the skull removed so that he could ejaculate on her brain (*Maclean's*, 8 February 1993, pp. 18–24).

Theriault's father, a member of an ultra-right Catholic group called the White Berets, physically abused Theriault as a child. A former next-door neighbour is quoted as saying: 'The mother was no better. You would hear her screaming at the kids from three-quarters of a mile down the road, like no other person could scream.' I assume this is the tip of the iceberg concerning Theriault's childhood trauma.

One should suspect severe childhood physical, sexual, and emotional abuse whenever there is a history of sexual compulsivity, violent or sado-masochistic relationships in adulthood, prostitution, extreme promiscuity, repeated suicide attempts, severe alcohol or drug dependency, behaviours that combine violence and sexuality, or, in extreme cases, serial murder and cannibalism. None of these things *proves* an abusive

childhood, but their presence compels a careful enquiry about childhood trauma.

In terms of physical and medical problems, besides direct indicators such as self-inflicted cuts and burns, a variety of physical problems are probably more common in sexual abuse survivors, though few studies have been done. Because adolescents and adults who were sexually abused as children are often more promiscuous, they are more at risk for venereal diseases, including AIDS, hepatitis, pelvic inflammatory disease, infertility, ectopic pregnancy, unexplained pelvic pain, and other genito-urinary and gynaecological problems. The relationship between childhood sexual abuse and severe premenstrual syndrome should be studied.

In a study published in the *Canadian Medical Association Journal* (Jeffries et al., 1985), risk factors for AIDS in homosexual men were examined. In the study, the risk factor of number of lifetime sexual partners was divided into two categories: 0–100 and greater than 100. It seems reasonable to me to speculate that some of this extreme promiscuity might be driven by childhood sexual abuse, since there does not appear to be anything inherent in homosexuality itself which causes promiscuity.

In an unpublished study I did with Jennifer Siemens at the University of Manitoba, we compared three groups of gastro-enterological patients on a variety of symptom clusters and childhood sexual abuse histories: of the three groups (irritable bowel syndrome, Crohn's disease or ulcerative colitis, and other gastro-enterological disorders), the irritable-bowel patients had far higher rates of childhood sexual abuse and other psychosomatic symptoms but did not differ on a wide range of dissociative and other symptom clusters. The differences between groups could not be accounted for by demographic factors.

The psychiatric problems commonly found in childhood sexual abuse survivors, besides dissociative disorders and borderline personality disorder, include depression, post-traumatic stress disorder, somatization disorder, substance abuse, eating disorders, sleep disorders, panic disorder, and psychosexual dysfunctions. According to preliminary research I have completed (Ross, Anderson, and Clark, 1994), childhood physical and sexual abuse are three times more common, even in supposedly biological mental illnesses like schizophrenia, than in the general population, and significantly affect the schizophrenia symptom profile.

It is important not to conclude that most people with the above-named psychiatric diagnoses must have been abused as children: that

conclusion is warranted only in relation to certain disorders such as MPD and borderline personality disorder. What serious childhood trauma does is increase the risk for other *DSM-IV* disorders, such as depression, which in a general-population study I conducted (Ross, 1991b) was 3.5 times more common in survivors of childhood physical or sexual abuse than among those who had not been so abused. However, this does not imply that the majority of people who are clinically depressed have been abused.

One of the indicators that a patient may be an abuse survivor is failure to respond to standard treatment for a psychiatric disorder. Also survivors tend to receive a large variety of different diagnoses and ineffective treatments, a theme I return to when discussing MPD. According to my trauma model of psychopathology (Ross, 1992; Ross and Pam, 1995), a history of childhood trauma affects the onset, course, symptom profile, treatment response, long-term outcome, pattern of family transmission, psychobiology, and response to psychopharmacology and psychotherapy of all psychiatric disorders. In some disorders, this effect is overwhelming and, in some, negligible; therefore, there exists a hierarchy of psychiatric disorders in which rates of severe childhood trauma increase as one moves up. Comparison of traumatized and non-traumatized subgroups within any given diagnosis should be an essential part of most research studies in psychiatry if the model is correct.

Given the above, one would predict that severe childhood trauma would have a profound impact on memory. One would anticipate that severe psychosocial trauma would result in deletions, inversions, insertions, misreadings, activations, and deactivations of memory, just as biological trauma does to the structure and processing of DNA. Disorders of memory are very common in survivors, and I would venture to say universal, once a certain threshold of severity and duration is exceeded. These disorders of memory should be viewed as an inevitable consequence of the trauma, and no more a reflection on the person's character than is DNA pathology caused by biological trauma.

Clearly, the understanding and assessment of Satanic ritual abuse survivors must be set in a broad context of the long-term consequences of severe childhood trauma.

The Psychodynamics of Child Sexual Abuse

The sexually abused child copes with his or her trauma at an age-appropriate cognitive and developmental level, with regressions to earlier lev-

els. Certain psychodynamic processes appear to be nearly universal in survivors of severe child abuse, and I will describe these before going on to explain their manifestations in cases of MPD and Satanic ritual abuse.

First, let me describe a birthday party at which I played the role of a masked and caped space monster. The theme of this sixth-birthday party was 'Astronauts and Outer Space,' with moon-rock candy, space balloons, space napkins, a space cake, and space prizes. One of the games involved the children going upstairs in shifts to find four pieces of hidden 'moon rock' (actually, pieces of gravel) each, then returning downstairs to collect their prize. The children were warned that there might be a space monster upstairs, and my son spoiled the surprise by announcing several times, 'It's just my dad!'

Forewarned of the identity of the space monster, the first four children came up the stairs and began searching, whereupon I came around the corner in a mask and cape, and growled, 'Who's eating my moon candy?' The children ran down the stairs screaming, and several began to cry. When I came downstairs and took off the mask, several children did not stop crying, and some would not go upstairs for fear there was another monster up there. One child who did venture up kept a death grip on the accompanying adult's hand. On the way home in the car with her mother, this child said, 'I'd like to have him come to my birthday party to scare the kids!,' thereby exhibiting the normal psychological foundations of repetition compulsion and addiction to the trauma.

This is the child's world, and it is in this world that childhood sexual abuse takes place, alter personalties are created, and the child is absorbed into a protective realm of inner fantasy. It would have been very interesting to interview the children two weeks later, to document the amount of distortion in their recollections of this birthday party. And how easy it would be to orchestrate 'parties' in which sexual acts were performed but the children's accounts of them were unbelievable.

Repetition compulsion is a classical Freudian concept that is best illustrated by trauma survivors. It is probably rooted in the brain's innate methods of dealing with trauma. In repetition compulsion, individuals repeatedly re-expose themselves to situations which re-enact the trauma, in a fruitless attempt to master the experience. This process is vividly illustrated in Lenore Terr's book *Too Scared to Cry* (1990). It is probably the foundation of recurrent themes and images in the works of Alfred Hitchcock, Edgar Allan Poe, and Stephen King, according to Terr. In adulthood, the survivor may become entrapped in behavioural patterns that continuously re-expose him or her to abuse.

There is an element of addiction in this process because the terror probably releases the brain's endogenous opiates, the endorphins, creating an internal high that, in some cases, can be blocked with an opiate-blocker like naltrexone, resulting in extinction of the self-destructive behaviour. Naltrexone is used in medicine to reverse the effects of heroin overdoses, because it blocks the action of heroin, an exogenous opiate, on the brain.

The child who wanted the scary space monster at her birthday party was exhibiting a perfectly normal childhood reaction to a mildly traumatic event which was also fun, which is precisely the point: childhood sexual abuse is terrifying, but there is also often an element of sexual arousal and longed-for attention in it. The psychology of a child's response to childhood sexual abuse is an extension of normal psychology.

One of the consequences of child abuse is for the child to feel bad, quite naturally. The psychological management of these bad feelings is influenced by what, in social psychology, is called an 'attributional error': the child attributes the cause of the abuse to herself. Instead of the abuse making her feel bad, she *is* bad, according to developmentally normal logic. This basic bad feeling about the self gives rise to the fundamental principles of both borderline personality disorder and the myth of Satan, as I describe in a subsequent chapter.

The abused child inevitably learns to confuse sexuality and self-worth. Although the abuse makes her feel bad, it also gives her power over the perpetrator and makes her a prized object, a role in which she can become entrapped in adulthood, feeling that she is worth nothing if she is not desired sexually by a man and that she is powerless if she is not making another sexual conquest. The abuse creates a core set of borderline double binds: incestuous sex feels bad, but it feels good to feel bad, and being bad is the only way to be good, although only bad girls would be good in that way, though good girls like to make their dads feel good, which makes them feel good too, even though the incest makes Mother feel bad, which makes the girl feel bad, the cure for that bad feeling being sex with Dad. The double binds are created, not just by the sexual acts in isolation, but by normal brain physiology, statements made by the perpetrator, and the psychological effects on the child of other developmental experiences and family dynamics.

It is not possible to understand the psychology and memories of Satanic ritual abuse survivors without having at least a preliminary understanding of the psychodynamics of childhood sexual abuse. Since

normal memory involves insertions, deletions, transpositions, and a variety of reading errors (Loftus and Ketcham, 1994), we would expect that severe trauma memory *must* involve a considerable amount of distortion, but that is no reason for therapists or survivors to be defensive, and the inaccuracy and imprecision of normal memory does not weigh against the reality of multigenerational orthodox Satanic cults.

The Internal Structure of MPD Personality Systems

The internal structure of MPD personality systems is described in detail in two of my texts (1989; 1994) and one by Putnam (1989); I provide only an overview here. Data I gathered in a mail-out questionnaire survey (Ross, Norton, and Wozney, 1989) replicated and extended an earlier study by Frank Putnam (Putnam et al., 1986). In both these studies, MPD personality systems had the same basic structure: in about 85 per cent of cases in my study, the respondents, who were mental-health professionals, reported the presence of three basic types of alter personality: a child personality, a persecutor, and a protector.

This triad of alter personalities is psychodynamically similar to God, Jesus, and Satan, if one considers that Jesus is God's injured son, Satan his persecutor, and God his protector. This basic triad of alter personalities might not exist in MPD cases arising in non–Judaeo-Christian cultures, or it might take a different form. In MPD systems, the child alter personalities usually hold the traumatic memories and have borne the brunt of mankind's earthly sin. The traumatized-child alter personality is the split-off identity created in childhood to be the victim of the abuse, and is usually separated from the host personality by an amnesia barrier. Usually most inner children hold bad feelings, but not all hold the feeling of being bad: some of the children may be quite cheerful and well adjusted, despite the abuse they experienced.

The cognition of being bad is held by the persecutor personalities, who believe that the children or the host caused the abuse and deserves to be punished further. The persecutors act out this cognition on the skin of the host personality through cutting and burning. The natural tendency of the organism to protect itself then gives rise to protector personalities, some of whom are classified by therapists as 'internal self-helpers' (ISHs) (Comstock, 1991; 1992). The ISH is regarded by some therapists in the field as an internal representation of transcendent or divine energies, and is thought to have paranormal powers, making my analogy with God more plausible.

The sequence in which the basic triad is created in childhood has not been studied directly because the field has not yet focused enough clinical attention on children in various stages of forming MPD. Likewise, whether alter personalities are usually formed by a gradual process of increasing differentiation or most commonly appear *de novo* as fully differentiated separate identities is not known, although retrospective reconstruction during the therapy of adults suggests that both processes occur.

The core internal structure of Judaeo-Christian MPD is well demonstrated in Satanic ritual abuse cases. The structural logic of MPD personality systems is another manifestation of the psychology of Satan because the system contains within itself the disavowed negative elements of the psyche, yet views them as *not self* or alien.

The Problem of Attachment to the Perpetrator

A universal problem in abuse survivors, including those who report Satanic ritual abuse, is ongoing attachment to the perpetrator. The trauma bond with the incest father gets re-enacted in the transference, in ongoing relationships in the present, and in confabulated Satanic memories at a symbolic level. The problem, expressed theologically, is the dilemma of how to love a good God who contains within him the Evil Enemy.

The sexually abused child aged four to eight has an insoluble problem. Her father in fact protects her, provides a roof and food for her, and at times is a reasonable and loving parent. The world is far too big and frightening for the child to run away from home, and she cannot in reality move into an apartment of her own, go away to college, or live on the street. She is trapped in the home with a loving father who also terrorizes and sexually abuses her. She is trapped in attachment to her perpetrator, both situationally and by her unavoidable mammalian attachment to her father. The child does not have the option of not being attached to, dependent on, or loving and needing her father.

The incest father's behaviour in objective reality is not integrated and does not make sense. The fact that at some times he is loving and kind and at others a rapist does not make sense, especially to a child still in early Piagetian stages of development. The child cannot introject and identify with an integrated father because one does not exist in the outside world. Even without additional trauma-driven dissociation activated to cope with the traumatic emotions arising from the incest, the

child is at risk for fragmentation of self because her father is not integrated behaviourally. It is no surprise that such a child cannot integrate God and Satan.

If, as is common, the child derives pleasure from the unavoidable physiological and erotic arousal caused by the sexual contact, attachment to the perpetrator is reinforced because the abuse becomes a source of physical pleasure, attention, affection, and special status. All these factors bind the incest father's 'Princess' tighter to her perpetrator. The core problem in therapy, then, is not the content of the memories as such but, rather, the traumatic attachment. The child cannot let go of Satan because she will lose God. This dilemma gets acted out repeatedly in many facets of her life, into adulthood.

Symbolically, this conflict is expressed by Satanic ritual abuse survivors in the oft-heard statement 'My father was a high priest in the cult.' The therapeutic response is, not to debate the historical accuracy of this claim, but to shift the discussion to the problem of attachment to the perpetrator, because the trauma bond exists no matter what percentage of the Satanic memories are real. The therapy must address the psychological fact that having a Satanic high priest as a father also makes one more special in the eyes of God, and therefore more protected and safe.

The Clinical Picture of Satanic Ritual Abuse

Several books could be written describing the clinical picture of Satanic ritual abuse cases in detail, and I give only a brief summary here. It is curious that there is so much disagreement about the existence of something that is described in such a sketchy fashion in the professional literature, by believers and skeptics alike. Except for single-case studies written for a general readership, detailed description of the phenomenology of these cases is lacking, even in the peer-reviewed literature.

Ritual abuse survivors with MPD exhibit all the signs and symptoms of severe, chronic childhood trauma, and in the vast majority of cases these symptoms have been observed by mental-health professionals long before the MPD was diagnosed and before any ritual abuse memories were uncovered. The average MPD patient in the large series referred to above (Ross, Horton, and Wozney, 1989; Putnam et al., 1986) spent 6.8 years in the mental-health system before the MPD was diagnosed. This definite and established fact must be accounted for in any theory or model of Satanic ritual abuse memories.

What is it that is distinct or different about ritual as compared to non-ritual cases of MPD? Except for the content of the memories, and the existence of a larger number of personalities and fragments, not much. The basic logic of the disorder, and the externally emitted signs and symptoms, are about the same in the two groups. To the extent that this is true, the debate about Satanic ritual abuse has no real clinical validity or foundation. Having said that, I now emphasize the unique and specific features of ritual abuse cases.

Ritual abuse patients talk about and are preoccupied with calendar dates in a way that non-ritual cases never do: even when non-ritual cases have extensive exposure to their Satanic ritual abuse peers on in-patient units and in group therapy, they are not contaminated by this preoccupation, at least in my clinical experience. One would expect the key date to be Hallowe'en, and we anticipated a sharp increase in admissions of ritual abuse cases in late October 1992 but saw none. Nor did we observe an increase in admissions prior to Hallowe'en or any other Satanic holidays in 1992, 1993, or 1994.

The dates which cause patients the most trouble on our unit, in terms of increased anxiety and agitation, are 21 December, 2 February, Easter, 21 June, and 7 September. This is interesting because, until I did the necessary background reading and accumulated sufficient clinical experience, I was unaware of the ritual significance of these dates. The date 21 December is particularly difficult on an in-patient unit because it is retraumatizing for survivors of non-Satanic ritual abuse as well, including those abused within deviant secret societies and New Age cults.

The solstice dates are easy to account for, as is Easter, since it is a key time to invert and mock Christianity; 2 February is Satanic Revels and 7 September is the Marriage to the Beast of Satan. Other significant dates include 30 April, Walpurgisnacht; 25 February, St Walpurgis Day; and 1 August, Lammas Day. Trying to keep track of all the Satanic holidays is impossible and unproductive because there are so many based on numerological permutations of birthdays, thirteenth days of the month, and other dates chosen for unknown or idiosyncratic reasons.

On an in-patient unit there may be an observable groundswell of agitation, acting-out, insomnia, and cutting for a period of time before key Satanic holidays. Specific dates are significant in another way unique to ritually abused cases: they are programmed suicide dates. I have never heard of a suicide plan set for an otherwise insignificant but specific calendar date in a non-ritual case. The dates can be a topic in psychotherapy for months in advance and are sometimes set in the survivor's

thirty-third year, which I assume has something to do with Jesus dying at age thirty-three. Sometimes the programmed suicide is to occur on or before a certain birthday.

The survivors claim, once you get deep enough into their personality systems, that the suicide dates, often with back-up dates, were deliberately programmed in by the cult, and they will identify specific alters that were programmed, and how it was done with a combinaton of torture, sexual abuse, and hypnotic suggestion. Records of medical examiners and law-enforcement agencies for years prior to the emergence of Satanic ritual abuse 'hysteria' could be examined for statistically significant clustering of completed suicides, disappearances, and murders on key Satanic holidays. If there was a positive finding, it could not be accounted for by a hysteria, contamination, or suggestion mechanism.

Ritual abuse survivors also mutilate themselves in ways that are never seen in non-ritual cases. They carve obvious Satanic symbols on themselves that could easily be explained by contamination and hysteria, such as pentagrams, the Seal of Solomon, inverted crosses, and words such as 'Hell,' 'Die,' and 'Satan.' However, more subtle forms of self-mutilation are also common and are done under fine control, and with draughtsman's precision. These may be placed carefully on specific body sites of no obvious significance, and may involve sets of straight lines, usually but not always in threes and sixes, or geometrical shapes, or other designs that are not stereotypically Satanic.

In our culture, the vast majority of non-ritual abuse survivors restrict their cutting to the forearms. Cutting on breasts, throat, thighs, labia, or other locations is presumptive evidence of extreme sexual trauma, often of an allegedly ritual nature. Like the general psychiatric history, these patterns of cutting can be established long before the MPD is diagnosed or ritual abuse memories are uncovered in therapy. One patient, whose father was a Nazi sympathizer during the Second World War, had alter personalities who carved the word 'Odessa' on her arm and thigh prior to the host personality's recovering memories of non-Satanic ritualized torture by the Nazis. 'Odessa' was a German organization formed at the end of the war to secure passports and changes of identity, and make relocation arrangements for high-ranking members of the Gestapo and the SS, and other Nazis.

The content of the drawings of Satanic ritual abuse survivors is also characteristic. Like the cutting, which is done on a canvas of skin, the drawings often contain obvious Satanic symbols, such as pentagrams and inverted crosses, and also pictorial narrative accounts of groups of

hooded figures sexually abusing girls and killing babies with sacrificial daggers. Snakes, spiders, children in cages that look like the bamboo prisoner cages from Vietnam war movies, altars, daggers, goblets, skulls, individual candles and candles in sets of six are common. Circles, triangles, wavey lines, lightning bolts, or other icons often appear in groups of six, seven, nine, or thirteen.

Red and black figure prominently in the drawings, and there is usually a copious amount of blood depicted. Disembodied eyes that look like the Masonic eye on the U.S. dollar bill are also common. Art therapists could give a more detailed account of how the quadrants of the drawings are used, and the icons placed in them. It would be interesting to do a study in which extreme skeptics about Satanism, highly hypnotizable college students, and non-ritual MPD patients never exposed to ritual cases were asked to produce a series of drawings typical of a survivor of a Satanic cult. The subjects could then be assigned to group categories by art therapists, based on examination of the drawings, and both a statistical and a narrative account of the study published. I predict that it would be difficult to fake convincingly a Satanic ritual abuse drawing.

The diaries of ritual abuse cases are not as distinctive but sometimes contain specific Satanic content. Although I have never made systematic clinical observations on this point, I suspect that ritual abuse diaries more frequently contain violent, slashing pen strokes.

Moving to the interior of the survivor, I now briefly describe the structure and organization of Satanic ritual abuse personality systems. There is a great deal of variability in these systems, depending on the mix of multigenerational orthodox Satanism, Ku Klux Klan, neo-Nazi, or other white-supremacist involvement; non-Satanic ritual abuse; and other forms of traumatic experience. The surface public religion practised by the family also has an effect, with demonic imagery often appearing in the drawings and personality systems of non-ritual cases from Catholic and fundamentalist backgrounds.

The basic Judaeo-Christian triad is always present in concrete form. The system is usually divided into a 'dark side' and a 'light side,' and therapists and survivors frequently refer to the 'dark-side alters' or 'bringing alters over from the dark side.' The dark-side alters always include the cutters, the sexually promiscuous, the most deeply programmed, and the cult-loyal personality states. Usually at least one is identified as a demon, Satan, or the high-priest father, and often the light-side system believes literally that the body is psychically or

demonically possessed. The two sides are locked in an adversarial battle at the beginning of therapy, and commonly there is a history of attempted exorcisms, extensive prayer healing, and other unsuccessful attempts at religious cleansing.

The internal Satan is usually depicted in stereotypical form in survivor drawings, and is regarded by the light-side system as powerful, evil, and continuously plotting the overthrow of the light side. In many polyfragmented systems, Satan is the leader of a parliament of entities that replicates the structure of Milton's Hell in *Paradise Lost*. Usually the dark side has a considerable degree of structure, with layers of increasing evil located farther and farther away from the host personality, like the structure of the medieval universe. Satan himself is usually located far at the back of the system.

During therapy, the lower demons take executive control and form a treatment alliance first, with more and more powerful entities entering therapy sequentially, until the Master appears. Sometimes it is possible to bypass several levels of lower demons and call out high-ranking demons, or Satan himself, early in therapy, but this is unusual because Satan is too frightened to appear. In my experience, Satan always turns out be a frightened-child alter personality (I discuss this phenomenon further in the next two chapters).

The light side also often has a hierarchical structure, with increasingly knowledgable and transcendent helpers located farther and farther away from the host and entering therapy sequentially. It is much easier to form a treatment alliance with high-ranking entities on the light side than with their counterparts on the dark side, although the helpers may prefer to work in the background unannounced until well into therapy.

I have briefly described the inner structure of Satanic personality systems to highlight the cultural theme of the myth of Satan, which they embody in a vivid, concrete fashion. Other features of the personality system characteristic of ritual cases include chains of fragments created to handle a single ceremony, the existence of numerous special-purpose fragments with assigned tasks in the cult, alter personalities deliberately named by outside people, and specific commands and codes inserted in the system for accessing alters from the outside. None of these features is ever seen in non-ritual, non–mind-controlled cases.

The Ritual Activities Described by Survivors in Therapy

I will close this chapter by briefly describing the Satanic ritual abuse

activities reported by survivors of multigenerational orthodox cults. They largely conform to public stereotypes of Satanism. Survivors report ceremonies and rituals involving intercourse on altars; chanting; wearing of robes; use of black, white, or red candles; ceremonial cutting with daggers; ritual murder with cannibalism of the heart and other organs; pentagrams; collection of blood, urine, and semen in goblets for group drinking; elaborate preparations of the survivor before the rituals; and murder of victims at the point of orgasm. There is usually a high priest who wears distinct garb and is clearly in command.

All of these details could be confabulated, based on information obtainable on television or at any bookstore. More convincing are small details reported by the survivors which are previously unknown to the therapist on first hearing, but then are described by other survivors from other parts of the country who have had no contact with one another. Some of the detail cannot be explained away in any plausible fashion by urban myth, rumour panic, and transmission of information through a survivor network. The details may include specific symbols on robes, certain statements made during ceremonies, or specific ceremonial rules.

It is also essential to understand that criminal ritual abuse reported by survivors is not limited to Satanic cults. I can differentiate orthodox Satanic from other forms of ritual abuse by drawings produced early in therapy – prior to recovery of detailed memories, for instance. Patients coming from voodoo backgrounds describe procedures and beliefs never reported to occur in Satanic cults, and those from KKK families describe murders of blacks, cross-burnings, and events which conform to documented activities of the Klan. When a patient describes a Klan murder from the early 1960s, followed by sexual abuse of Klan children, I do not experience anywhere near the degree of incredulity elicited by Satanic cult memories, and my reaction makes me consider the possible reality of multigenerational orthodox Satanism more seriously. The same applies to a small number of cases I have seen from Central America in which the patient describes typical documented rituals of Santería, including sacrifice of chickens.

The point is that survivor memories contain a wealth of detail not generally diffused throughout the culture, combined with elements known to everyone. Also, the memories are not stereotyped, and vary significantly, depending on the type of ritual abuse: the non-Satanic cults described by survivors are even less known to the general public, and identifying some symbols requires considerable research beyond sources available to the general public. To explain some of the detail by

any other hypothesis than the reality of the cult, one would have to postulate deliberate archival research by alter personalities for the conscious purpose of constructing confabulated memories.

Conclusions

To treat Satanic ritual abuse with a balanced therapeutic approach, it is necessary to have an adequate context. Part of this context is a knowledge of the long-term consequences of incest, some understanding of the inner structure of non-ritual MPD systems, and at least basic information about the actual content of survivor memories which goes beyond stereotype and impressionism. The clinical fact that many signs and symptoms of severe childhood trauma, multiple personality disorder, and ritual abuse can be documented in psychiatric records long before the MPD was diagnosed or the ritual memories recovered must be accounted for by any adequate model of Satanism, as must the reporting of detail not generally available in rumour networks or the public domain.

9

General Principles of Survivor Therapy

The psychotherapy of multiple personality disorder must always be based on sound general principles. Most of the destructive therapeutic practices I hear about, or consult on, involve violations of standard, general principles of psychotherapy, and are not related to technical problems peculiar to MPD. Thankfully, the majority of my supervision is with therapists who are practising ethical, intelligent, well-managed psychotherapy and need assistance with problems that emerge as a result of the intrinsic difficulty of their cases. I have provided ongoing paid supervision and consultation to between twenty and twenty-five mental-health professionals, most of whom are seeing Satanic ritual abuse cases, and we generally have at least fifteen MPD patients with ritual abuse backgrounds on our Dissociative Disorders Unit, where the average length of stay is three weeks, so I am accumulating a considerable volume of direct and indirect clinical experience. I have directly treated, provided supervision on, or provided group therapy to about three hundred alleged survivors of Satanic ritual abuse.

The psychotherapy of MPD patients with Satanic ritual abuse histories must be based on general principles of MPD psychotherapy, and should differ from the treatment of non-ritual cases as little as possible. Most of the serious treatment errors I see in ritual abuse cases are caused by the therapist losing sight of general principles.

In this chapter, I review these general principles of the psychotherapy of MPD, illustrate their application to Satanic ritual abuse cases, and discuss some additional clinical guidelines specific to the treatment of MPD. (I give more detailed case-histories in the next chapter.) I alternate the use of 'I' and 'we' in this chapter because I use the strategies personally, and we also use them collectively on our unit.

Limits, Boundaries, and Ethical Rules

In order to create and maintain a healthy, healing psychotherapy, it is essential to have clear rules and boundaries. This is true of all organisms and social structures, as exemplified by the amoeba, which has fluid, permeable cell walls in order to facilitate transport of water and nutrients. The amoeba would die if its cell walls ruptured, became excessively rigid, or became excessively permeable: the integrity of the organism, and its biological survival, depend on a balance of rigidity and fluidity, structure and flexibility. Psychotherapy is an amoeba.

Although there is a grey zone in which disagreements can be based on personal preference, there are absolute boundaries which must be maintained. I tend to be rigid about therapy rules in comparison with most non-medical therapists in the dissociative-disorders field and probably am flexible compared with most academic psychiatrists. The rules of therapy I follow include:

1 No sexual contact between therapist and client.
2 No weapons brought into sessions.
3 No threats against the therapist's family.
4 The client does not enter the therapist's home (if the therapist's office is in his or her home, Satanic ritual abuse clients usually should be seen elsewhere).
5 Excessive numbers of phone calls are not permissible (the definition of 'excessive' varies widely).
6 The client is not given the therapist's home phone number.
7 The therapist's personal life is not discussed, except perhaps in the most general manner to illustrate some point being made in the therapy.
8 Therapist and client do not socialize outside therapy.
9 The client does not know the therapist's family members' names.
10 Therapy usually does not exceed three hours per week, except during periods of crisis or in cases where this can be done without fostering dependency and regression.

Some of these rules are absolute, and some admit flexibility. For instance, some therapists give out their home phone numbers and can tolerate frequent phone calls without any problem arising personally or in the therapy. Farther along the spectrum of boundary violations, I have seen cases in which the survivor had a personal relationship with the

therapist's spouse, based on talking to the spouse on the phone. In one case, a ritually abused female client with MPD took her male therapist's secretary's daughter to dancing lessons, went to aerobics classes with the secretary, and kissed the therapist several times while sitting on his lap in his living-room during therapy sessions. The alter personality doing the kissing felt the therapist was a father, an adolescent watching in the background was sexually aroused, and others were enraged, but the therapist was not talking directly to any of the alter personalities. A great deal of work was required to help this woman deal with her conflicted relationship with her prior therapist.

In another case, a female client with MPD was given a birthday party by her male therapist's secretary, to whom the therapist was married, complete with a birthday cake, subsequent to which the client accused the therapist of having intercourse with her. It appeared that the intercourse never took place, but the re-enactment of the incest family, with the secretary as mother and the therapist as father, stimulated confabulated memories of intercourse with the therapist based on an underlying paternal-incest history. The therapist was managing the client's finances for her, much as a father would do for his incompetent or delinquent daughter.

In an extreme case, according to partially substantiated allegations by a survivor, the client was a live-in lover of her therapist while in therapy, and was also contributing tens of thousands of dollars to the therapist's business venture, on top of paying therapy fees. In several cases I have worked with, patients have made clinically plausible but uninvestigated allegations that a previous therapist had deliberately called out child alter personalities to have sex with them and had instructed the children not to tell the adult personalities. A related case in which I had no involvement went to court and resulted in a guilty verdict, though in that case it was not a therapist who called out the alter personality. A professional on our unit has seen a photograph of a patient in bed with her previous therapist, both of them wearing nightgowns.

Severe boundary violations sufficient for a successful malpractice suit are common in the mental-health field. Because survivors of severe childhood trauma have had countless violations of their boundaries through emotional, sexual, and physical abuse, they are highly prone to re-exploitation, and their therapists must pay careful attention to the treatment frame. I have consulted on a number of cases in which the therapist was spending more than ten hours a week with his or her client, and uniformly the clients were regressed, dependent, and self-

destructive. The only exception to this rule that I have seen is a case in which the client and therapist are part of a healthy, structured religious community, and the social norms of the community allow intensive attention and support for limited periods of time.

I have seen many cases in which the therapist is depleted, angry, and resentful towards the survivor because of intrusions into the therapist's personal space, yet the therapist's proposed solution is to allow even more intrusions, which are rationalized as needed support and nurturance. Whenever the therapist is able to take the consultation advice and reduce the quantity of contact, the therapy has always gone better, and the number of crises has been reduced. Many therapies are out of control because of a positive-feedback loop, in which escalating amounts of attention are instituted for escalating numbers of crises. I advise against ritual abuse clients being seen in a home office because that environment seems to stimulate sadistic fantasies towards the therapist and increase the likelihood of the therapist developing post-traumatic stress disorder.

The most healthy possible change in the dissociative-disorders field would be for therapists to tighten their boundaries, since loose boundaries are the most pervasive problem in the field. One reason for this is evident in the previously mentioned data collected at the MPD meeting in June 1992 by Barry Cohen, MA ATR; Joan Turkus, MD; Christine Courtois, PhD; and myself: of about 1,000 registrants, 379 mental-health professionals completed the trauma section of the Dissociative Disorders Interview Schedule and the Dissociative Experiences Scale. Of the female respondents, 60 per cent gave a history of childhood sexual abuse; of the males, 36.7 per cent gave such a history (the difference was significant at $p < .001$).

The sexual trauma prior to age eighteen reported by these professionals was serious; for instance, 63 women reported abusive intercourse with a male; 62 reported performing fellatio; 38 had cunnilingus performed on them by a male; 11 reported enforced sex with animals; and 16 reported participation in pornographic photography. The average duration of sexual abuse for the women was 7.5 years; of the 379 respondents, 118 reported sexual abuse starting before age eight. Particularly disturbing were the considerable number of respondents who were unsure of the identities of their perpetrators, the types of sexual abuse perpetrated, and their ages when the abuse started and stopped.

One reason for the excessive number of boundary violations in the therapies of sexual abuse survivors is the large number of therapists who themselves have significant amnesia and unresolved trauma his-

tories. Based on the fact that 5 per cent of the respondents scored above 30 on the Dissociative Experiences Scale, I would guess that at least 1 per cent of therapists in the dissociative-disorders field themselves have multiple personality disorder, and I suspect that the actual percentage could be three times this figure. This calculation is based on data from the study by Eve Carlson in which 17 per cent of a sample of 1,051 clinical subjects scoring above 30 on the DES had MPD (Carlson et al., 1993). Therapists with dissociative disorders are having difficulty understanding what their own historical reality is, let alone anyone else's; therefore, it is not surprising that therapeutic errors are made.

Depending on the degree of overlap between the categories of offender–therapist and dissociative-disordered therapist, as many as 15 per cent of professionals providing treatment to Satanic ritual abuse survivors either could be sexual offenders or could have dissociative disorders, and probably more than 50 per cent have sexual-abuse histories of some kind. (I return to these figures and this theme in chapter 11.) Such data serve to highlight the need for attention to boundaries.

Satanic Ritual Abuse Treatment as a Destructive Psychotherapy Cult

I have seen cases in which a major trauma appears to be the therapy itself. In these cases the patient meets *DSM-IV* criteria for the form of dissociative disorder not otherwise specified as 'states of dissociation that occur in individuals who have been subjected to periods of prolonged and intensive coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive)' (American Psychiatric Association, 1994, p. 490).

The patients have been psychologically captive in their therapies and have been trained to believe that outsiders and family members are Satanists. Like people who have been recruited into the Moonies, the Satanic ritual abuse survivor is disconnected from her family and indoctrinated against her parents, and restricts her life space to a massive overdependence on the therapist. Her friends become other cult members, who are often in treatment with the same therapist or with other therapists in a restricted network of professionals who know one another personally. Protest against the therapy is regarded as evidence of cult programming and is treated with increased coercive persuasion. In December 1994, I reviewed a paper submitted to a peer-reviewed journal which expressed absolute, uncritical belief that Satanic cults program patients against therapy between sessions on a widespread scale.

Such psychotherapy cults often have a charismatic leader; practise deceptive recruitment; restrict the patient's life space, social contacts, and information sources; and, in extreme instances, inflict prolonged sensory deprivation, sedative medications, physical restraint, and other mind-control techniques in hospitals. The cults have a loose hierarchical structure and do not tolerate opposing ideologies. Patients who have escaped from such cults require 'exit counselling' as much as do survivors of the Moonies or any other destructive cult.

From this comentary it should not be concluded that the appearance of Satanic ritual abuse memories is proof that the therapy is a destructive cult; such memories also occur in ethical and helpful therapies. As stated previously, the key consideration is how the case is managed, not whether the patient has confabulated memories. When the patient is exiting from a destructive psychotherapy cult, the problem of attachment to the perpetrator must be resolved, in part, in terms of attachment to the destructive therapist.

Problems Caused by the Patient Being Regarded as Special

The specialness of trauma survivors is discussed intelligently and at length in the September 1992 issue of the journal *Dissociation* (available from the Ridgeview Institute, 3995 South Cobb Drive, Smyrna, Georgia, 30080). The major problem with 'specialness' is that it fosters boundary violations of the types described above. Satanic ritual abuse survivors with MPD should be treated as special in the same way that kidney-dialysis patients get special attention: the specialness is inherent in the specific disorder and its treatment, but the patients are not special as human beings by virtue of their disorder.

The kind of specialness one sees in MPD psychotherapies too often is a re-enactment of the specialness of the little girl to her incestuous father, and in fact many sexually abused girls are called 'special,' 'precious,' or other such terms of endearment. This psychodynamic is apparent in a one-page parable one patient's therapist had handed out to her and other sexual-abuse victims. The therapist regarded the parable as a good example of God's wisdom and love for abuse survivors.

In the parable, God and the archangel Michael are discussing God's plan to send a little girl to earth to be born into an incest family, where she will be sexually abused. Michael cannot understand why God would send this innocent girl into such a family, and asks him why he does not send a boy instead, since boys are tougher. God answers that

the toughness of boys is only skin deep, but girls have a deeper strength, and he says that this little girl is especially strong. Not only that, God explains, the abuse she is going to experience will make her a more deeply spiritual child, who will have a special mission on earth. The parable ends with Michael marvelling at the depth of God's insight and wisdom.

The problem with this story is that it is based on perpetrator's logic. God is telling the girl the same thing that incestuous fathers say – that the abuse will make her special, that it is their special secret, that it will make her a better woman and wife, and that it is being done because of Daddy's love. Survivors with this kind of background will not feel better because they are being treated as special, despite the fact that certain alter personalities will accept, and demand, an infinite amount of 'special' attention. The psychology of Satanic ritual abuse survivors is the same but involves a higher level of drama and deviance: the ritual abuse survivor was so special that she was in training to be a high priestess. The psychodynamics are the same, whether this is a confabulation, a lie told by the perpetrators, or a historical fact.

I have emphasized the theme of specialness because it is such a common cause of boundary violations. The specialness of incest survivors may take a grandiose form, as in the Satanic high priestess, but the vast majority of the time it goes in the opposite direction: the survivor believes herself to be specially bad, culpable, ugly, and unworthy, and takes excessive responsibility for all negative events and outcomes in her life. It is important to understand the psychological foundation of the specialness of abuse survivors in order to deal with it effectively in treatment.

The little boy or girl who is being sexually abused often has no avenue of escape because of threats by the perpetrator, guilt, shame, and disbelief of disclosures by adults. The only escape for the child is in the mind, through dissociation and amnesia. One of the most traumatic qualities of the abuse is not just the abuse incidents themselves, however, but the helplessness and powerlessness they create in the child. The traumatized child creates an *illusion* of power and control in order to counter her overwhelming loss of control, apparently because dissociation alone does not do the job.

Technically phrased, the child displaces the locus of control for the abuse from the perpetrator to herself (she brings Satan inside herself). Now it is the little girl herself who is causing the abuse to happen: this restoration of power appears to be developmentally protective, even

though illusory. The cost of the psychological strategy is that, because she is in control of the abuse, the girl becomes responsible for it, and therefore bad. In developmentally appropriate logic, the child reasons that the abuse happens because she is bad, because she deserves it, and because she causes it to happen, through either an excess of badness or a deficiency of goodness. Examples of the latter, in the child's mind, are abuse caused by failure to eat properly, keep a tidy enough bedroom, or do well enough at school.

This sense of badness and responsibility for the abuse may contribute to the little girl being trapped in an abusive marriage when she grows up, and it is a major component of the drive to cutting, burning, and other self-destructive behaviours of the adult survivor. For the survivor of Satanic ritual abuse, her badness is proven by the fact that she bore babies for the cult, participated in human sacrifices, and did not prevent ritual intercourse between herself and Satan. If these events never occurred, they are confabulations created to entrench the theme of badness; if they did occur, they reinforce it. In either event, the therapy must address the developmental wisdom and protectiveness of the illusion of badness, while clearly pointing out its destructive consequences in the present and its lack of developmental utility at this stage of life.

The most 'special' alter personalities of all in Satanic ritual abuse survivors are the ones who believe themselves to be demons or Satan. To reinforce the trauma-driven specialness of these personalities by therapist fearfulness, attempted exorcism of the demonic alter personalities, or anything other than an even-handed treatment approach will impede recovery. To allow special privileges because there is an 'entity' named Satan inside will reinforce the belief that the personality state is literally Satan and will interfere with the process of bringing Satan into therapy. It is incongruous to treat someone as special because he or she has Satan inside, but this is in effect what many therapists do when they allow special privileges for the host and child alter personalities in ritual abuse cases. The therapeutic error re-enacts the ancient cultural theme of Satan as dissociated Enemy, with the host personality taking the role of Good Angel.

In the next chapter, I give detailed examples of how I approach and work with demonic and Satanic alter personalities in ritual abuse survivors. The specific interventions are based on a foundation of non-specialness which recognizes that every human spirit is special: it is not the abuse or the MPD that makes the person special, however. The person

who is seen as special because he or she has MPD will fear loss of the therapist on recovery, and will therefore resist the therapy.

A Problem-Oriented Treatment Approach

In setting up the Dissociative Disorders Unit at Charter Behavioral Health System of Dallas, I deliberately, for a number of reasons, created a Master Treatment Plan with a problem-oriented approach. The first reason is that this is the best way to proceed clinically because mental-health professionals treat clinical problems, not disorders as such, which is true in medicine generally: certain disorders are not treated if they are causing the person no trouble, as a result of temporary or permanent remission, or because the condition is benign in nature. Multiple personality disorder is not, in and of itself, a reason for psychiatric treatment; rather, it is the problems that the MPD causes which require attention.

Another reason for a problem-oriented approach is that it permits operationalization of treatment-outcome criteria, and thereby lays the foundation for the treatment-outcome studies I will be conducting in the future. Third, a problem-oriented approach is a requirement for good relations with insurance companies, employee-assistance plans, managed-care companies, hospital-inspection agencies, and other outside parties who control the finances of the health-care system. Third-party payers quite rightly want to see evidence of a return on their investment and are no longer content to accept what the doctor says merely because he or she is a doctor. In terms of ritual abuse cases, insurance companies should not be paying to keep people in hospital to prevent them from attending cult meetings, whether or not the meetings are real.

In order for a dissociative-disorders unit in a private hospital to survive financially in the 1990s, it is essential for the unit director, and other administrative professionals, to pay close attention to average length of stay, payer mix, collection rates, amount of extra nursing required, national marketing strategies, relationships with referring therapists, and other factors that are the realities of a for-profit business environment. Failure to manage these variables effectively will result in closure of the unit, resulting in loss of service to all patients and loss of jobs among unit staff. All of these pressures demand a short-term acute-care model and a problem-oriented treatment approach. The in-patient psychotherapy of Satanic ritual abuse survivors on dissociative-disorders units in the United States has to be much more rigorously 'realistic' than the in-patient practice I was familiar with in a teaching hospital in Canada.

The average length of stay on the Dissociative Disorders Unit is eighteen days, compared with thirty days for general adult in-patient psychiatry in Canada. This is particularly remarkable when one considers that 50 per cent of our MPD cases come from out of state, and 25 per cent from within Texas but outside the Dallas–Fort Worth area: our cases are a highly skewed sample selected for degree of crisis and therapeutic difficulty, and our typical patient would be the most difficult client in many mental-health professionals' caseloads.

Being involved in a cult is not a problem we treat, nor is having a background of childhood Satanic ritual abuse. In the majority of cases, the reason for hospitalization is active suicidal ideation, often with cutting, burning, a recent overdose, or specific plans for a method of suicide. Our problem list contains the typical reasons for admission of any patient to an acute-care general psychiatric unit, and we include no problems in our list which are specific to MPD (the Charter Behavioral Health System of Dallas Dissociative Disorders Unit Master Treatment Plan may be obtained by calling 1-800-255-3312 or 214-618-3939, and asking for 'Needs Assessment').

My ideal is for the treatment of MPD to become as standardized as the cognitive therapy of depression (Beck et al., 1976), and for knowledgeable professionals to be able to predict my treatment plans accurately. I generally create a treatment plan during the initial assessment; during the course of the admission, details about specific alter personalities are added, but the plan undergoes little fundamental revision.

Consider the presenting problem of suicidal ideation in a patient with MPD. In my first admission note, which generally fills three-quarters of a page, I might list the following:

1 Map personality system more completely.
2 Form treatment alliances with the chief persecutor alters involved in the cutting and suicidal ideation.
3 Increase interpersonality communication and cooperation.
4 Devise alternative behavioural strategies to meet the persecutor personalities' needs.
5 Limited trauma-memory recovering and processing related to specific memories driving the suicidal ideation.
6 Three-week admission.

The treatment plan is focused on the presenting problem, involves intensive work with the personality system, and has as a discharge goal

remission of the presenting problem. The actual work to be done varies in its details, depending on current external stresses; the structure of the personality system; the stage of therapy the patient is at; the personal strengths, resources, and supports of the patient; and other considerations. The details of the psychotherapy vary at a content level from patient to patient.

In-patient treatment plans for Satanic ritual abuse survivors with MPD should be standardized, just as they are for depression, but should be tailored to the individual case, as is done for other disorders. For details of how to conduct the psychotherapy of MPD, I refer the reader again to two of my books (1989; 1994) and to one of Putnam's (1989).

Dealing with Double Binds

For case examples of the management of double binds in dissociative-disorder patients, one should read some of the cases in *The Osiris Complex* (Ross, 1994). I have never treated a case of MPD that did not involve numerous double binds within the personality system, and in the person's transactional patterns with outside people, including the therapist. Although I have no supportive data to offer, my clinical intuition is that the internal double binds were created in response to double binds in the childhood family system, whereas the dissociation results more from the specific traumatic experiences.

The double-binding logic becomes intertwined with the personality system because different alter personalities hold and act out different components of the binds. The dissociation then reinforces the double-bound structure of the personality system because the contradictions and incompatibilities cannot be resolved, owing to their compartmentalization and lack of interaction.

What is a double bind? In its simplest form, a double bind is a no-win situation, an example being the dilemma of shutting down the personality system to reduce symptoms, thereby prolonging the period of suffering but at reduced intensity, versus opening up and increasing the short-term level of pain in order to achieve an earlier long-term resolution. Looked at in a short-term perspective, this appears to be no-win: attempts to shut down the system result in greater resistance and acting-out by persecutory alters, while opening the system up has the same effect. A typical solution to this problem is an overdose, which is an attempt to exit from the field.

In MPD patients, double binds can become very intricate in their

structure, with chains of double binds, and tertiary or quarternary binds in place. The main thing for the therapist to do is avoid getting caught inside the binding system; being caught will result in the therapist owning the problem, which will prevent it from having a solution.

For example, a skilled therapist had a dilemma because her male patient was indirectly disclosing ongoing perpetration of sexual abuse of children. He was making indirect statements which were clearly veiled disclosures, and identifying the victims by name, but would not supply sufficient direct information to trigger action. Child Protective Services was already involved in the extended-family system and was also unable to get clear disclosures from perpetrators or victims. The family system was very complex, with many individuals having psychiatric disorders and as many as four or five members simultaneously being admitted to hospital, each to a different one, for family crises.

The double bind was that attempts to press the issue were met with suicidal ideation and possibly increased sexual abuse of nephews; ignoring the ongoing paedophilia left the victims unprotected. The therapist was caught inside the family system and was experiencing personal pain and personal responsibility for fixing the family's psychopathology: bringing the therapist inside the system ensured maintenance of the status quo, with the added benefit that the therapist carried the pain for the family.

My consultation recommendation was for the therapist to state directly to her client that she could not work with him while he was abusing children and that, to continue working with her, he would have to disclose to Child Protective Services, and get into treatment for his paedophilia. This resulted in immediate hospitalization for acute suicidal ideation, partial disclosure to hospital personnel, and a request by the patient for the therapist to continue working with him. My advice at this point was for the therapist to get out of the case because the double binds in the family were too entrenched, and the patient's commitment to recovery was too weak. Since the patient was in hospital, and since the therapist did not do forensic work or have expertise in the treatment of male offenders, and because of the personal emotional cost to her and the risk of violent acting-out against her, I advised her to withdraw from the case while her client was in hospital, and while a higher-ranking mental-health professional, the attending psychiatrist, had control of the case and medico-legal responsibility for it. This advice was followed, and the therapist was freed from entrapment in endless double binds.

The basic strategy in dealing with double binds is best illustrated in

the movie *War Games*, in which a military computer advises a protagonist caught in an escalating positive-feedback loop that 'the only way to win is not to play the game.' Dealing with double binds requires a systemic approach, empowerment of the survivor, and limit-setting. This fact illustrates the point that all techniques, principles, and interventions in the treatment of MPD are intertwined, and separable only for teaching purposes.

In another case, I was asked to give a consultation opinion on the post-discharge placement of a patient whose discharge was being delayed by increased symptoms and the breakdown of attempts to find a suitable group home or supervised setting. Here the double bind was that sending the patient home was unacceptable, in the patient's view, because it meant returning her to an abusive relationship with a man who had involved her in child pornography and continued to abuse her sexually and physically in adulthood. The degree of reality of these allegations of ongoing abuse was suspect. The other half of the bind was that the patient had complex MPD and was actively suicidal, with some self-mutilation, and therefore was not suitable for placement in the available group homes. The hospital and treatment team had accepted ownership of her placement problem and thus were paralysed, with the patient's length of stay increasing well beyond a reasonable period, and being just short of her calendar-year maximum (when a patient reaches the calendar-year maximum number of days, he or she cannot be readmitted on an insured basis until the next calendar year).

This was a double double-bind; in order to maintain the health of the Dissociative Disorders Unit, it is necessary not to alienate managed-care companies such as the one involved in this case, and the reviewer was pressing for discharge. To please the managed-care company, the correct action would have been to discharge the patient to return home, but she countered this move with suicidal ideation, projection of responsibility onto staff, and statements that the admission would then be a waste of her calendar-year days, raising the possibility of either a suit or pressure for free treatment, too much of which will destroy the unit. My recommendation was to set a fixed discharge date one week away and make the patient responsible for finding a place to stay, which she did.

Double binds in the psychotherapy of Satanic ritual abuse survivors are frequent and inevitable and should be handled in the same way as in non-ritual cases. The main difficulty for the therapist is that stepping out of the double binds often increases the level of suicidal ideation in the short term, and this must be tolerated by the therapist without collapse

back into the binds. Here, a double double bind arises when the therapist imagines trying to explain to an incredulous jury why the amount of care was intentionally reduced because the level of suicidal ideation had increased, when, from a common-sense point of view, such circumstances would appear to require an increase in the amount of support and treatment. One anticipates short-term retaliation from the patient in the form of suicidal statements, blaming the therapist, and escalation of symptoms, followed by improved function and decreased symptoms, if the intervention works; but, if it fails, the retaliation may come from a jury. All outcomes lead to abuse of the therapist in one form or another, the hope being that stepping out of the bind reduces the duration and intensity of the retaliation.

Dealing with a pre-discharge escalation of symptoms and threats of self-mutilation is a frequent component of the last few days of an inpatient stay. At times it is necessary to tolerate superficial cutting and burning with cigarettes, both pre- and post-discharge, without readmitting the patient, and I will state directly to the persecutor alters making the suicide threats that acting-out will not result in readmission. In some cases, I set fixed periods of time during which a discharged patient will not be readmitted and tell the patient that within such periods readmission will have to be to another facility.

Work with Satanic ritual abuse survivors involves firmer and more difficult limit-setting, and extrication from more complex double binds, than does conventional psychiatry.

Alter Personalities Are Not People

The therapy will not go well if the alter personalities are treated as separate people. Though this is true, hostile skeptics often state that they do not believe in treating alter personalities as separate people, as if not doing so is a simple matter which can be taken care of by monolithic legislation. One of the most common errors made in mismanaged cases treated by clinicians who do not believe in MPD is that the alter personalities are suppressed and directly told that they are not real. This results in the alters hiding inside, as if they actually are hateful separate people who are interfering with 'the patient.' This, in turn, reinforces the dissociation and the patient's cognitive error that separate parts of the self are separate people. The skeptical therapist thinks that this approach has resulted in remission of a disorder that never existed in the first place, not realizing that the suggestion *not* to have MPD can have a powerful

but transient effect, yet is only a suggestion and does not create a permanent reality.

One of the foundations of the treatment of MPD is the fact that suggestion and instruction can go in two directions, towards regression, dependency, and the sick role, and towards health. What extreme skeptics fail to understand is the strategic complexity of the therapy required to produce health, a fact which is underlined by the period of just under seven years that the average MPD patient spends in the mental-health system prior to diagnosis (Ross, 1989).

A related and common error is to believe that the host personality is the real person, while the alter personalities are secondary elaborations. Therapists who are skeptical about MPD but partially accept its reality often talk about 'strengthening' the patient and eliminating the need for the alter personalities, when what they are actually doing is reinforcing the degree of dissociaton between the host and other alter personalities. Often such therapists are unaware that the current host is actually a group of co-conscious alter personalities with separate names and ages, all of whom answer to the person's legal name, while the prior host, who has the legal name, is hidden inside. The therapist will be talking about strengthening Julie, when Julie isn't even in treatment, and will observe switching in sessions without seeing it.

The major conceptual error made by skeptics is that, though they insist that alter personalities are not people, they manage MPD cases by regarding one of the alters as the person; often this selection of an alter personality as the person is quite arbitrary. Skeptics who treat the host personality as the person unwittingly fall prey to the illusion that alter personalities are actual people.

Another skeptical conceptual error is the idea that the alter personalties did not pre-exist contact with the therapist and therefore are artefacts of the therapy. This proposition is simply not supported by the clinical facts; a long history of blank spells and auditory hallucinations can be obtained on initial assessment, prior to any questioning that could possibly provide a cue to fake MPD. Clear signs and symptoms of MPD can usually be found in the psychiatric records of undiagnosed cases of MPD stretching back for years, and I have examined emergency-department consultations in which alter personalities are described by name but MPD is not mentioned and other diagnoses are given.

In one such consultation report, a history of possession of a gun, prior death threats by the patient against his son (the patient was a male single parent), voices in the head, blank spells, named alter personalities,

and current active suicidal and homicidal ideation was documented, but MPD was not mentioned, and the patient was sent home without follow-up and without notification of Child and Family Services.

I mention these cases to illustrate that iatrogenic complications can arise from failure to diagnose MPD and institute proper case management. In the case of the homicidal male single parent, failure to acknowledge the reality of the alter personalities probably increased the risk of severe trauma to the patient's child. If such violence did occur, and the patient returned to the emergency department amnesic for murdering his son, the most likely misdiagnosis would be malingering, with intermittent explosive disorder and antisocial personality disorder also mentioned. Successful malpractice suits based on failure to diagnose MPD, with immediate serious consequences to the patient and/or others, will probably become more common throughout the rest of the decade.

It is essential to treat the alter personalities *as if* they are separate people, while stating explicitly that they are all parts of one person; doing so establishes the most solid treatment alliance with the parts who experience themselves as literally separate people, yet discourages secondary gain and evasion of responsibility.

I explain directly to the host and other alter personalities the protective nature of the illusion of separateness, and frame it as a positive survival strategy which served them well in childhood but is now causing problems. I often directly explain to the patient why the dissociative defence would not work without a full illusion of separateness, and might say, 'If you spent your childhood saying to yourself that you were really just one person, and didn't really have Satan inside you, and if you knew full well that Satan was just something you had created to hold your feelings and memories, then the whole system wouldn't work.' I describe such interventions in more detail in the next chapter.

The Major Cause of Suicide Attempts Is Anger

The most widespread lay understanding of suicide attempts is that they are a 'cry for help.' Actually this is a rare motive for self-destructive behaviour among Satanic ritual abuse survivors, trauma survivors in general, and people with MPD. It is essential to understand that the majority of so-called suicide attempts have nothing to do with trying to die: this is often partially understood in the mental-health care system, but then interpreted as indicating that the attempt 'really wasn't seri-

ous.' This is a misunderstanding: the self-harm was a very serious attempt; it just wasn't an attempt to die.

The common purposes of self-abusive behaviour are to regulate internal states, mete out internal punishment, manipulate outside people, and suppress memories. The most common associated emotion is anger. This is evident if one, for a moment, goes inside the illusion of separateness and thinks of the alter personalities as separate people: why do people stab, burn, cut, and otherwise physically abuse each other? Such behaviour between actually separate people in domestic situations usually occurs in a violent, stormy, emotionally charged context. It is rarely perceived as passive, kind, or helpful, or a cause for 'caring,' nurturing, or empathic responses from others. The same holds within an MPD personality system.

A common error is to view cutting and burning as evidence that the survivor is out of control, and therefore requires a controlling, parenting response from the mental-health system, usually admission to hospital. This is true and not true. The logic is the inverse of that seen in bulimia. A bulimic patient often will state that she is in control of her behaviour because she can vomit whenever she wants, and thereby keep her weight well regulated. This is actually true, which is why bulimia is such a self-reinforcing illness in a culture that prizes both material consumption and thinness. The problem, of course, is that the bulimic is actually out of control.

In a cognitive-behavioural treatment for bulimia, I will intervene by entrapping the bulimic in her own logical contradiction. I will get her to state in response to leading questioning that she is fully in control of her vomiting, and in fact is so skilled that she can induce vomiting at will, without even having to stick her finger down her throat. Then I will say, 'All right, if you are in full control of your behaviour, why don't you stop bingeing and vomiting for a month, starting now, to demonstrate to me that you really are in control.'

The bulimic patient will reply that she can't possibly do that; then, I explore the reasons why, and the cognitive errors behind them. Like the cutting in MPD patients, the bingeing is usually used to regulate mood and self-esteem, and the basic false assumption is that the person will be completely unlovable if even five pounds overweight. In bulimia I try to break the illusion of control by trapping the patient into acknowledging that she is out of control, which she really knows already. I then state that the goal of the therapy is to devise alternative strategies to maintain her weight without vomiting, and I agree that if we simply took away

her current coping strategy, without inserting an alternative, she would certainly gain weight, and that would be a bad outcome. I do this because the patient is highly averse to taking any risk which appears to involve potential weight gain.

For the Satanic ritual abuse survivor who has 'dark-side' alters cutting on her, the therapeutic strategy runs in reverse. Here, the patient feels out of control, and the paradox is that the cutting is being done carefully and deliberately for a specific purpose, and in addition is usually effective. The host personality feels out of control because she does not experience herself as the agent of the cutting, is often amnesic for it, and does not understand its motivation or helpfulness.

By working with the cutting alter personalities directly to understand their motivation, and the function of their behaviour in the personality system, and by fostering a dialogue between the host and these other alters, I set the stage for negotiation of a different behavioural strategy to replace the cutting. Commonly, the so-called evil alter personality is cutting to try to suppress a memory in process of coming back to the host, the evil alter's problem being that he is being flooded with the traumatic feelings linked to the memory. In this situation, I might contract for gradual memory recovery at a tolerable pace, and suggest the creation of a safe place inside for the evil alter to rest in isolation from the traumatic feelings and visual memory, and will educate the host about the positive intent of the evil alter's behaviour and its fear of the memories.

The main principle is that the self-destructive behaviour has a specific systemic purpose, and a meaning which needs to be understood in order for symptom resolution to occur. A common error in the therapies of Satanic ritual abuse survivors is for the therapist to overidentify with the host and frightened-child personalities, and to form an alliance with them against the bad alters, who are not really bad. This is a repetition of our cultural myth of Satan as the Evil Enemy, and, in fact, I understood the cultural dynamics by, first, analysing MPD personality systems and, then, generalizing to a cultural level.

Overidentification with the frightened host personality also fosters fear, paranoia, and secondary post-traumatic stress disorder in the therapist, while entrenching the victim role of the host. Part of the correction of the cognitive errors of the host involves educating her about the fact that anger is a vital source of energy, motivation, and positive change in the world. I often make this point by asking the host personality what she thinks the major motivator of the women's movement has been, and

then follow up by pointing out that, without that anger, childhood sexual abuse would not have come out of the closet, the dissociative-disorders field would not exist, we would not be sitting in this room talking, and she would not be able to get therapy for her MPD and have a chance at recovery.

We have the angry, cutting alter personalities do a great deal of anger work in therapy, and we redefine their anger as reasonable and legitimate, given their childhoods, while emphasizing that they need to learn how to express it constructively. We also point out that anger is necessary for safety and survival: this reinforces the treatment alliance with the cutters and helps redefine them as protectors, because we point out that other alters in the system have been abused in adult life because they have been too trusting and not angry and assertive enough.

Cutting may be used to reverse depersonalization, and is often effective for this purpose. The cutting alter will say that she needs to see blood in order to feel real. This is a complicated problem, which may be helped by treatment with the medication fluoxetine or naltrexone while the system work is being done. The general approach is still the same, however, with the systemic function of the symptom, the alter personalities directly involved in the symptom, and its basis in childhood trauma being the focuses of the interventions.

It is widely believed that suicidal ideation is a direct symptom of depression, which is partly true. There are not enough research findings to support my alternative view, but I believe it to be correct nevertheless: I suspect that suicidal ideation is more directly related to childhood sexual abuse, statistically and correlationally, in the general population, than to depression as such. The problem in the field is that more than 99 per cent of published studies of depression ignore childhood sexual abuse completely. Whether this relationship is true outside MPD or not, I cannot say for sure, but within sexual abuse survivors, the following rule applies: where there is depression, anger is not far away.

Most of the time, the clinical depression of MPD patients is a negative state caused by the dissociation of the organism's energy and anger. In some cases, the entire personality system appears to be depleted and depressed, but most often it is only a sector which is deprived of energy, resulting in a downward spiral of fatigue, demoralization, and hopelessness. Usually the host personality, and perhaps some of the helper personalities, are depressed, while child alters are in a post-traumatic state, or are cheerful and unaffected. In such systems, the actively suicidal

alters are the angry persecutors in the background and are full of energy and not the least bit depressed. The goal of the treatment is to integrate them into the system, replenishing the depleted energy of the depressed personality states.

In a Satanic ritual abuse survivor, the angry, energized personality states are often defined as demonic, and therefore further excluded from contact and interaction with the host, which compounds the problem. Successful intervention may require the correction of cognitive errors in the host personality, the demons, and the therapist. Therapies will go wrong when the Satanic alters are viewed as literally demonic, and the host is thereby deprived of their energies. The therapy of Satanic ritual abuse survivors must be based on general principles, as illustrated by these considerations.

Empowering the Survivor

Empowerment is a major theme of the women's movement, yet it is surprising how often survivors are not empowered in therapy. Empowerment gets undermined in two ways – errors of omission and errors of commission – and the challenge is to avoid both.

The errors of omission usually involve failing to teach the patient that she is in fact a clever, creative survivor, as is evidenced by the MPD. It is important to define the survivor as an autonomous, capable adult, because this can be a self-fulfilling prophecy (the reverse is also true). Respect for the survivor as an independent adult can be communicated in numerous small ways with tone of voice, body language, and minor interventions and statements made throughout therapy. These errors of omission cannot be avoided by the therapist making statements he or she does not really believe.

The errors of commission are more common and troublesome. Here the client is regarded as incapable of handling ongoing life problems without massive input and support from the therapist, which requires that boundary violations be carried out. The enmeshed, overinvolved therapist is doing the opposite of empowering the client. The therapist in such situations may be paralysed by fear of cutting or completed suicide and, in Satanic ritual abuse cases, is fearful of the client being accessed, reinvolved in rituals, or reprogrammed by the cult. Empowerment of the survivor is achieved more through the overall *Gestalt* of therapy than by specific interventions, I think.

Satanic Ritual Abuse Surviors Are Not Programmed Robots

One of the most common errors in the treatment of ritual abuse survivors has to do with *programming*. In countertherapeutic therapies, the survivor is often viewed as programmed in a concrete manner, which renders her helpless in terms of being able to control her alter personalities or their behaviour. Therapists will frequently say of a client 'She couldn't help it, it was her programming,' or ask in consultation 'What do I do about programming?' My answer is 'Nothing.'

By 'programming,' many therapists mean a process in which the cult deliberately created alter personalities, implanted specific triggers to call them out, inserted suicide and return-to-the-cult programs, and in effect created a hypnotized robot. The reader who has grasped the inner logic of MPD will understand why I say that this is true and not true. It may be historically true that such programming was done, but this does not mean that the survivor is programmed in the way therapists often mean.

Too many therapists in the field think of programing as something concrete that was inserted into the survivor's brain from the outside, and is therefore foreign to her psyche. They talk about the client's 'programs' as if these are literal computer chips inserted into the person's brain, which has to be 'deprogrammed.' The client will regard herself as too dumb to fight the clever programming of the clever programmers, and will take a passive and helpless position in therapy. This is responded to with narcissistic grandiosity by the therapist, who is now the powerful, expert, and dramatic 'deprogrammer' fighting the evil machinations of the cult. The therapist becomes the 'light-side' mirror opposite of the 'dark-side' cult programmer, and the survivor is low-ranking and dependent in both relationships. The therapy becomes yet another permutation of the psychology of Satan.

In extreme cases, the deprogramming model massively escalates the cult hysteria, regression, and dependency of the survivor, and entraps her in a destructive psychotherapy cult. Survivors treated in such practices are in constant fear of being 'accessed' by the cult, drugged, raped, reprogrammed, kidnapped, murdered, or relocated to another state. These psychotherapy cults meet all the criteria for a destructive cult, as stated above: they practise deceptive recruitment, in that the client usually enters treatment for depression, an eating disorder, or some other problem and has no ritual abuse memories at first. The client is drawn deeper into a deviant belief system she is not allowed to question, and

resistance to the cult's ideology is explained by Satanic cult-implanted programs to resist therapy, which require deprogramming by the therapist. These clients unwittingly become members of a counter-cult cult, which is destructive whether or not the original cult ever existed.

I have seen marriages severely damaged by such psychotherapy cults, patients recruited away from competent therapists for induction into the cult, and flagrant insurance fraud practised by such therapists. However, I have also worked as a co-therapist with skilful, competent, and ethical therapists who believe in programming in a much more concrete fashion than I do: the problem with the deprogramming model is usually with its sociology, not its theory.

The deprogramming model seems to be serving a specific function within the dissociative-disorders field. The mistaken idea that MPD patients are not responsible for the actions of their alter personalities has been effectively blocked by the leading teachers in the field, though patient irresponsibility is still a straw man attacked by hostile skeptics. To compensate for the cancellation of the idea that MPD patients are not responsible for their behaviour, the severity of their trauma has been magnified into Satanic ritual abuse, and programming has been discovered. These countermoves return the deprogrammers to the position of authority they had lost, and the clients to their position of dependency. The primary psychological motive appears to be the therapists' need to be needed, plus the therapists' requirement for grandiose defences to compensate for inadequacy.

When a patient tells me that she is too dumb or too helpless to deprogram herself, I analyse the key cognitive error behind this mistaken belief. I point out that there was never actually anything inserted through the survivor's skull: the 'programs' were created inside the survivor's skull by her own brain in response to things the programmers were doing and saying. The programming can't be smarter than the patient, because she *is* the programming, and her mind couldn't create and maintain something more intelligent than itself. I argue further that she would not have been programmable if her IQ was 30.

Having made these points, I then normalize the process of programming, and say that programming occurs, for example, when an incestuous father with a tenth-grade education comes into his daughter's bedroom at night drunk, rapes her, and tells her she will die if she talks. This experience installs a powerful fear program in the victim's mind which plays over and over for years. Sophisticated cult programmers, if they exist, are simply doing this in a more deliberate and calculated

fashion. I also remark that we are all programmed by our culture, our language, advertising, and many forces we encounter in daily life, so programming is not a special and mysterious process known only to cult programmers. It is not a violation of our civil liberties that we are programmed to speak English.

These interventions usually create a much more positive working attitude, de-escalate the hysteria, and reduce dependency on the therapist quite quickly. However, the psychotherapy of traumatically implanted programming is arduous and difficult, no matter how it is framed. My rule-of-thumb is that so-called deprogramming is only a combination of cognitive therapy and guided imagery. The therapist's task is to understand the structure and rules of the system, learn how to move around in the system, and help the system reorganize itself into a healthier mode of function. It does not matter if the imagery and rules of the system involve programs, robots, guards, and numeric access codes, or goblins and fairies, because the conceptualization of the therapy is the same in all cases.

To clarify my position: it may appear from these remarks that I do not believe in sophisticated mind control and programming; however, quite the opposite is true. The problem with the deprogramming model is not that there is no programming, but that implementation of the model too often involves inherent cognitive errors and disempowerment of clients.

Correcting Cognitive Errors

The extensive use I make of cognitive therapy in treating MPD and Satanic ritual abuse is evident from the preceding sections of this chapter. For those readers who are not mental-health professionals, I will briefly review the core principle of cognitive therapy and illustrate some of its applications in the psychotherapy of MPD. A comprehensive cognitive analysis of MPD and relevant references are included in my text *Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment* (1989).

Cognitive therapy is a school of psychotherapy developed by Aaron Beck for the treatment of depression, and it has since been generalized for use with a wide variety of disorders and problems. The basic rationale of cognitive therapy is quite simple, and can be illustrated with an anecdote.

A woman is alone in her bedroom at night when she hears a noise downstairs. She concludes that the dog has knocked over the water dish,

decides to leave it till morning since the dish was empty, has no particular emotional response, goes to bed, and has a good night's sleep, waking refreshed in the morning. On another night the same woman hears exactly the same sound, but concludes that a rapist–murderer has broken into her house and is about to come upstairs. Now she dials 911, waits in bed paralysed with fear for the police to arrive, and, even after the police determine that the dog made the noise, has trouble going to sleep, has a bad night's sleep interrupted by nightmares, and wakes in the morning feeling tired, foolish, and frightened.

The key difference in the two scenarios is the woman's thoughts or cognitions. The mistaken thought that a rapist caused the noise creates a cascade of distressing and dysfunctional thoughts, feelings, and behaviours, and a state of physiological hyperarousal. Clearly, the key point of intervention in this sequence of events is the cognitive error. Cognitive therapy works by analysing, making conscious, and correcting automatic and erroneous thoughts and assumptions which create depression, panic attacks, and other symptoms. In well-designed studies, cognitive therapy has been shown to be as effective for clinical depression as antidepressant medication.

Many of the MPD patient's difficulties are attributable to cognitive errors, some of which are specific to MPD and some of which are related to childhood trauma more than to MPD as such. An example of a cognitive error almost universal in severely sexually abused adults is the idea that they caused and deserved the abuse, as discussed previously. In survivors with multiple personality disorder, this cognitive error is dissociated into subcomponents which are held and acted-out by different alter personalties.

For instance, in an MPD patient, the host personality may be amnesic for paternal incest and may have an idealized view of her father. A number of child alter personalities hold the memories and traumatic feelings, while the cognition of badness is held by a persecutor personality. The difference between the persecutor personality and a survivor without MPD is that the persecutor says *'She* is bad' rather than *'I* am bad.' The persecutor often believes that she herself was never abused, that the host's father is not her father, and that she has a separate physical body from that of the host personality, on whom she inflicts cigarette burns and razor-blade cuts.

The treatment of the cutting and burning involves addressing and correcting the universal cognitive error of badness, and the cognitive error of separate parts of the self being separate people, which is specific to

MPD. To do this, the therapist must understand the intertwining of these two cognitive errors in the behaviour of the alter personalities. In the next chapter, I give detailed examples of how these principles are instituted in Satanic ritual abuse cases.

A Systemic Treatment Approach

Like the cognitive-therapy component, the systems approach inherent in my work has been evident throughout this chapter. I will also explain it briefly for readers who are not mental-health professionals. The systems approach to mental-health problems has been developed primarily by the family-therapy movement, and is a clinical application of general systems theory. The basic idea in family therapy is that the family is a *system*, and that the structure, rules, organization, and function of the system are the focus of therapy, rather than the individual family members as such. An anecdote will illustrate how systems theory works in family therapy.

A couple comes to a mental-health professional because their thirteen-year-old son has been hanging around with the wrong crowd, staying out late, and stealing hubcaps. An asystemic approach would be to arrange for individual counselling for the boy, to change his behaviour. A family therapist, in contrast, will define the boy as the 'identified patient,' but will see the entire family for therapy at the same time, and define the *family* as his patient, not the boy.

A key initial task of the family therapist is to redefine the presenting problem, the boy's behaviour, as, in fact, the solution to a family problem. It follows that the next task is to figure out what problem the solution addresses, then help the family to create a more adaptive solution. In a simple scenario, the real problem in the family is the fact that the parents never talk, are drifting apart, and appear to be heading for divorce. The only thing they ever talk about, work on jointly, or show joint passion about is their son's behaviour, which is actually designed to keep the parents together. The more upset the parents get about their son's behaviour, the more they reinforce it.

The family therapist redefines the boy's bad behaviour as positive in intent, characterizes him as sacrificing his own interests for the greater good of the family, and recommends that the parents go out on a date once per week. There is a paradoxical component to this intervention: it defines the boy's bad behaviour as good, and since he doesn't want to be a goody-goody, he stops the good behaviour in order to appear bad,

which resolves the presenting problem, takes him out of the role of identified patient, and places the problem back in the parental generation. Of course, things are actually more complicated than this in the real world, and the therapy more difficult, but the anecdote illustrates the principles involved.

The psychotherapy of MPD must be systemic in nature because the disorder involves a system of dissociated personality states which functions like an inner family. Also, the disorder arises within families as a consequence of family dysfunction, and therefore compels the therapist to take a family-systems perspective. The key lesson to be learned from family therapy is that every symptom has meaning, and every presenting problem is actually a solution to a problem. The therapist must analyse the MPD case to understand the systemic meaning and function of each symptom, and must intervene in a way which takes this systemic function into account.

It is essential to view the entire personality system as the client, and not to form special alliances with individual alter personalities against others, because this places the therapist inside the system, as described above. The family-therapy literature takes great pains to emphasize that the therapist must remain neutral with respect to individual family members, and must align with the system as a whole. This doctrine is essential to good therapy of Satanic ritual abuse survivors, in whom the system is often divided into a good side and a dark side, with the two sides competing for the therapist's allegiance and favour.

Conclusions

In this chapter, I have reviewed some of the general principles of survivor therapy in order to lay a groundwork for the next chapter, in which I describe specific techniques and provide case examples which illustrate the blend of cognitive, systems, and psychodynamic techniques I use in treating ritual abuse survivors. I view the psychotherapy I do as eclectic in technique, but based on a comprehensive model of human psychology and history that I am still working out. My main point in this chapter is that the treatment of Satanic ritual abuse survivors must be based on general principles, and should not stray too far into special methods and techniques.

10

Treatment Techniques for Satanic Ritual Abuse Survivors

As I emphasized in the previous chapter, there are no special psychotherapy techniques for Satanic ritual abuse survivors. The survivors differ from people with non-ritual MPD only in the content of their memories and, in preliminary research we are conducting at Charter Behavioral Health System of Dallas, do not appear to differ in severity of symptoms on various research measures, though clinically they have more alter personalities and personality fragments. This chapter, then, is about the application of general principles and techniques to the treatment of MPD cases with ritual abuse memories.

Here, I review a number of different topics, and then illustrate the problem-oriented approach to several key clinical problems common in the treatment of this group of patients. The techniques can be used in any clinical setting, and do not require a hospital, any kind of special security, or any unusual equipment or facilities. The psychotherapy of Satanic ritual abuse survivors should consist almost entirely of a behaviourally unremarkable conversation between two adults, even though one party to the conversation is switching to alter personalities of different ages. If there is too much high drama in the therapy sessions, emotionally or behaviourally, something is wrong.

Management of Countertransference

The first priority of therapy is to take care of the therapist; a hostile, burned-out, or emotionally absent therapist will be of no benefit to the client. I have consulted to several therapists with full post-traumatic stress disorder they acquired from treating one ritual abuse case, and there is abundant evidence in the field of impaired therapists acting out

their fears. When therapists start arming themselves and being paranoid that the cult is watching their house or may kidnap them from their office parking lot, this behaviour is driven by post-traumatic symptoms, whether or not it is a realistic reaction to actual threats. I have talked with mental-health professionals who are experiencing intense fear and anxiety about the cult, and who require treatment for their cult fears.

One sign of post-traumatic countertransference in therapists is the way they say the word 'cult.' Both therapists and survivors often refer to *the* cult, as if the cult is a monolithic entity and as if all survivors of ritual abuse were abused by one giant organization. With a little experience in the field, one can hear the traumatic countertransference in the pronunciation of the word 'cult,' which is spoken as if from within a child's nightmare. Anyone interested in the psychobiology of trauma might be able to document that the most extreme survivor memories actually correlate electroencephographically with bursts of REM intrusion, which means brief periods of EEG activity consistent with a brain dream state.

Traumatized therapists have often been drawn too far into the patient's hypnotic reality, and identified too much with the child-like fears of the child alter personalities: this is a problem, whether or not the ritual abuse memories are real. Being drawn too far into the hypnotic nightmare, which is what ritual abuse would be for a child even if it was actually happening, is the inverse error of withdrawing and disconnecting from the client as part of a traumatic countertransference response.

Erotic countertransference, by contrast, in its healthy and natural forms, just means liking the patient, and is no different from liking one's bank teller or family doctor, though it is more intense. However, erotic feelings can get out of control, and get acted-out as sexual involvement with the survivor. The best antidote to this and other boundary violations in healthy therapists is to imagine that a group of colleagues is watching the session through a one-way mirror. If the therapist is about to do or say something that would be embarrassing in front of observers, it is time to stop and reconsider.

Satanic ritual abuse survivors evoke a wide range of feelings and reactions in therapists, from anger to sadness, eroticism, fear, disgust, depression, gaiety, and awe for the depth of the human spirit in both its beauty and its depravity. The psychotherapy of Satanic ritual abuse survivors takes the therapist on a journey into the heart of evil, sadism, and sexual perversion, and can be a difficult experience. It is not possible to work intensively with such people without undergoing a deep change in world-view.

When I was growing up in a normal middle-class city neighbourhood in Winnipeg, in the late 1950s and early 1960s, there were no drugs, gangs, AIDS, cults, Satanists, or murders, and none of my friends' homes had been broken into or their parents divorced. Cults were never mentioned or talked about. Now I live in a world which is ridden with destructive cults that adhere to countless fanatical doctrines, a world in which the Branch Davidians in Waco seem like part of everyday life. I look at world events from a very different perspective now, and think thoughts I would never have considered for a millisecond ten years ago.

Consider a therapist who has residual post-traumatic stress disorder from childhood sexual abuse, still has trauma nightmares, and is hypervigilant and fearful when alone at night. When this therapist works with clients who vividly relive participation in the ritual sacrifice of babies, children, and adults in cults alleged to include doctors, police officers, lawyers, judges, and Ku Klux Klan members, and the therapist believes these things to be ongoing sociological realities, the world begins to look very different. The modern world may be as ridden with destructive, bizarre, and deviant cults as any period in history: this is an unsettling possibility for even the most balanced therapist to contemplate. Ongoing self-care is essential for mental-health professionals working intensively with survivors of extreme trauma, even if part of the trauma is confabulated.

The purpose of this section has been to raise the issue of traumatic countertransference without attempting to review it in any detail. By far the most common countertransference error in the mental-health field is withdrawal from the trauma survivor in defensive self-protection.

Hypercomplex Personality Systems

Satanic ritual abuse cases are often polyfragmented, which means there can be dozens or hundreds of named entities inside; it is not possible to work directly with this many dissociated states if therapy is not to last for decades. An essential strategy in such cases is to deal with groups of alter personalities collectively, which is usually fairly easy. Often such systems are divided into distinct subsystems, such as the children, the dark-side alters, the helpers, Margaret and her group, the Baltimore people, the people in the cave, or some other designation which identifies their function or the period of life in which they were active.

Polyfragmented systems can have an elaborate internal structure reminiscent of a video game, with levels, layers, rooms and passageways, or

rivers, valleys, mountain retreats, safe gardens, witches' homes, and caves. Some system maps drawn by survivors look like engineering diagrams, and contain elaborate and obsessive detail. It is important for the therapist not to get lost in the detail, and to try not to work too much at a micro level in the system.

A typical intervention would be to have the host personality 'go talk to the children' or 'make a safe place for the children,' without the therapist ever having to speak directly with the children or know their individual names. In some systems, there are large groups of children, demons, soldiers, or other figures, none of whom appear to have an individual name. The important thing for the therapist to remember is the thematic meaning of the group, and its systemic function: the function is often carried out by the group as a whole.

I have had patients tell me that some of the named entities in the internal world are not alter personalities, and do not need to work in therapy, the principle here being that not all entities in the internal landscape require treatment. Some are simply internal visual representations of psychological themes, in which case the therapy needs to deal with the theme, not the representation. Some therapists feel that such internal entities can simply be vaporized, using whatever imagery is suitable for the client, and this is probably true of some systems, as long as the vaporization is done internally by the patient.

In extremely complex systems, it is usually helpful to integrate the members of a subsystem in order to reduce the information overload and internal crowdedness, even before the definitive work with the subsystem has been completed. This can result in declarations that 80 or 120 alters were integrated in one day, an indicator of the fact that they were never alter personalities in any meaningful sense of the word.

As noted earlier, in Satanic ritual abuse cases, it is very common for the system to be divided into a 'dark side' and a 'light side,' and this structure can give rise to a therapeutic error. The dark side usually contains numerous demons, often with Satan himself as the leader. The treatment error is for the therapist to function like an evangelist, sequentially converting individual members of an alien religion to Christianity. In such therapies, there can be lengthy admissions while dark-side alters are brought over into the light, one by one, but the supply of demons appears to be infinite, and the process can go on indefinitely if the underlying system themes are not addressed. Actual missionaries in the external world usually try to convert an entire tribe at once because they understand both the cost-effectiveness calcu-

lations involved and the quantity of demonic energy available in the universe.

For instance, one of the early missionaries in the western Canadian arctic was able to convert an entire group of Inuit from shamanism to Christianity with a single statement. According to the shamanic logic system, the most powerful shaman was the one who knew the most rules and laws of the spiritual cosmos, since he could best advise on how to appease the gods, secure game and good fortune, and acquire spiritual power. A smart shaman was much like a smart lawyer, in that he knew the rules of the system and how to play the game most effectively. The Anglican missionary demonstrated his superior shamanic power by introducing an entire new class of taboos no Inuit shaman had ever mentioned. The Inuit had never heard of the cosmic law that a certain *day* was sacred: they were familiar with places, animals, dead ancestors, gods, and natural forces being sacred, but the concept of a certain day's being sacred was entirely new.

When the missionary told the Inuit that Sunday was God's day of rest, they were astounded and immediately converted. Cynics might point to the fact that this conversion gave the Inuit a day off they had never had before, but that misses the point: logic systems are like diamonds and can be dramatically restructured if hit gently at just the right spot. One can convert an entire subsytem of demons with a single cognitive intervention if it is done correctly, reviewed several times, and presented in an irrefutable fashion. This is far more efficient than working with the demons one by one.

A pregnant Satanic cult survivor with MPD was having a great deal of conflict about whether her mother should be able to see the baby; the mother still had cult-involved alter personalities, as well as a severe personality disorder, and might manipulate, upset, or emotionally abuse mother and child if allowed contact, or physically abduct the baby for sacrifice. Conflict between the parents over this problem continued for months, with one group of the pregnant patient's alters making surreptitious phone calls to the mother out of guilt and allegiance, and another group threatening suicide if the husband blocked all involvement with the mother. Other subsystems were not directly involved in the conflict. The patient stated that she would rather kill herself than deny her mother visitation with her grandchild.

During a number of couple sessions, it appeared that the problem was the mother and what to do about her, but the problem was moving no closer to solution, and in fact was escalating as the pregnancy prog-

ressed. Cognitive-systems analysis of the problem provided a different perspective, and a marked reduction in marital conflict. As I was talking with one of the dark-side alters, I formulated the hypothesis that the mother was not really the issue, and that the conflict was an externalization of a conflict within the personality system. This hypothesis is a daily fact of MPD psychotherapy, in various forms.

The cognitive flaw in the patient's logic system became apparent as the timing and motive of suicide were described in more detail. The dark-side alter stated that she would commit suicide if not allowed access to her mother, and this appeared to be motivated by guilt about denying the mother access to her grandchild, allegiance to the cult, and collusion with a plan to sacrifice the baby after birth, all of which naturally fuelled the father's fears and resistance to visitation by his mother-in-law.

The flaw appeared when the alter personality stated that she would not commit suicide until after delivery. This statement had been made previously, but I hadn't grasped its significance: it was obvious that the evil, cult-reared, demonic alter personality was trying to protect the baby. This meant that neither mother, nor loyalty to mother and the cult, was the real issue; rather, the problem was an internal conflict about how to protect the baby. Grasping this, I pursued a line of questioning with the evil alter personality which revealed a very different conflict and motivation.

The alter, who was an adolescent, reasoned that she was bad, unfit and undeserving as a mother, and even dangerous to her baby, because she had allowed the cult to sacrifice her own baby in adolescence. There was a set of cognitive errors about the alter personality having any real autonomy and control within the cult, and therefore any real options or responsibility as an incestuously impregnated and terrorized child. These were addressed and required ongoing work. The key conflict, though, was over how to protect the baby.

The underlying logic of the proposed suicide, which was stated explicitly by this alter personality, was that, by killing herself post-partum, she would cut the baby off from her own evil nature and, more important, from her mother and the cult. The suicide would be a noble self-sacrifice for the greater good of the child, driven in part by cognitive errors that the cult abortions (another alter had a similar experience with another baby) proved the evil, dangerous nature of the pregnant patient. The dark alter said she did not deserve to have a baby because she had let the cult kill her last one.

This was a system problem, because another subsystem of alter per-

sonalities was unable to set healthy limits with the mother, owing to their child-like allegiance to her, combined with idealization and amnesia for the trauma inflicted by mother, both inside and outside the cult. My intervention had several facets, one of which was explaining the positive, caring motivation of the suicide to both the dark-side alters and the functioning adults. I also stated repeatedly and forcefully to the dark-side alters, with one in executive control, that there would be a huge hole in the baby's life if she committed suicide, and that the baby would deeply love the dark-side alters. They found this an amazing, revolutionary, and healing concept.

I also repeatedly emphasized that the mother-in-law was not the issue, a concept the husband grasped and believed immediately. I describe this intervention here because I dealt with the group of dark-side alter personalities, including several with cult abortion memories, as a collective, and checked to ensure that they were all co-conscious and listening, and I also did the same with the functioning adult group. To have reviewed all of this with ten or more separate alter personalities would have taken many sessions, wasted a great deal of time, and taken us beyond the delivery date. The vignette also illustrates the intertwining of cognitive, psychodynamic, and systems strategies, in that the primary psychodynamic drivers of the conflict were guilt, low self-esteem, and projection of hostility onto the grandmother.

The other major point is that the intervention works whether or not the cult memories are real, and is effective without the reality of the memories ever being debated. In fact, one could argue that, if the memories are confabulated exaggerations of psychodynamic conflicts, leaving them intact increases the power of the intervention, since the possible external consequences of access by the grandmother appear much higher, making the urgency and nobility of the self-sacrifice more compelling. This will result in a more rapid formation of internal respect and cooperation between the dark- and light-side alters, and thereby foster acceptance of the fact that the real problem is an internal conflict about pregnancy.

Is Satanic Ritual Abuse Real?

Most debate and discussion about Satanic cults, both inside and outside the dissociative disorders field, focus on whether or not they are real. This misdirection of attention sidesteps process and structural issues and traps the field in a fruitless fixation on content. Content is funda-

mentally important in a court of law but not in a psychotherapy office, and usually cannot be verified or disproven conclusively within the boundaries of a well-conducted therapy. Part of the problem is that the boundaries between the media, the psychotherapy office, and the courts are permeable, and therapists and survivors lose sight of the fact that different criteria apply in each sphere and cannot necessarily be transposed from one sphere to another.

'Believing the client' may appear to be a good guiding principle for therapy, but it directly conflicts with the legal principle of 'innocent until proven guilty' when a survivor sues a perpetrator. Principles of belief, conviction, support, and affirmation that may be helpful within the therapy framework may be destructive to both therapist and client if they foster groundless suits, media exposure, alienation of relatives, and countersuits. Therefore, it is essential to be cautious in transferring one's convictions as a private therapist into the public arena. These remarks have deliberately been phrased to be charitable to therapists, since it is questionable whether believing uncritically in confabulated memories can ever be helpful. The proper therapeutic stance, which is neutrality, avoids the problematic aspects of 'believing' the client.

The fact is that we don't know for a fact how much Satanic ritual abuse is actually going on in North America in the 1990s. All parties to the debate about the reality of Satanic ritual abuse should keep this fundamental principle in mind at all times.

The focus of the mental-health field should be on clarifying the therapeutic interventions which appear to be most helpful, in preparation for scientific treatment-outcome studies, not on debating a criminal-investigation issue. The best interventions are those which will be effective whether or not the memories are real, and I have seen them work both in clearly confabulated ritual abuse cases and in ones which appeared plausible and genuine. To emphasize, I have worked with Satanic ritual abuse memories which were impossible for me to believe, and with patients reporting mind control, abduction, child sacrifice, paedophilia, and sophisticated use of hypnosis who I judged could be giving me historical facts. In the majority of cases, I am not sure one way or the other, but do not worry about it much.

Conversations with Satan

A major guiding principle of therapy with Satanic ritual abuse survivors is 'making friends with Satan.' I have had many conversations with

Satan, and worked with one system in which there were several Satans, including Satan and Fake Satan. Actually, every Satan I have ever met has been a fake Satan. My infernal perambulations have established a previously unknown epidemiological fact: the average age of Satan in North America is about seven years. The basic principles of work with Satanic ritual abuse systems were first enunciated by William Blake in his work *The Marriage of Heaven and Hell*, which he etched between 1790 and 1793, and I refer the reader to that treatise.

General principles of MPD therapy include the need to form a treatment alliance with the persecutory alter personalities, bring them into therapy, increase communication and cooperation within the system, reduce amnesia, and reframe the persecutors' behaviour as positive in intention, while devising alternative behavioural strategies to meet the system's needs. These principles apply to work with Satan, who, once you get to know him, is one of the most enjoyable characters in the system, and also often the most hurt.

Almost every Satan or major internal monster I have worked with has turned out to be a child in disguise. For instance, in one system, Satan was hidden behind a massive steel door with molten lava flowing in front of it; the host personality thought this was evidence of the power and dangerousness of Satan, but actually the fortress was required to protect a badly abused child who was very frightened of the world. The Satan image was a scary disguise designed to frighten away the rest of the personality system and outsiders. As well, the identity of Satan helped to keep the host personality from coming anywhere near the memories, and therefore was also protective of the host.

I like the phrase 'changing job suits' because it evokes the magical wonder of the child's inner world, and transforms it from a literal hypnotic reality to a fantasy land of roles and costumes. Demons and Satans can voluntarily take off their job suits, once their underlying positive intent has been acknowledged, and they have been empowered to make their own decisions about things. In one system, a group of demonic alter personalities transformed themselves into Ewoks, and constructed an Ewok village, which served them well until they were integrated. Many patients can readily relate to *The Wizard of Oz*, and are pleased to discover that Satan is really just a scared Munchkin who fears rejection.

The fundamental principle is to reverse the projection of the bad self outside the self, and its personification as Satan, and to heal and integrate the disowned portion of psyche. I am always pleased to see the

host personality's expression of astonishment when I suggest, early in an admission, that I would like to get to know Satan and make friends with him.

A final point is that systems containing demons and Satan do not necessarily come from ritual abuse backgrounds, and can be treated to stable integration without any ritual abuse memories being uncovered. In such cases, the family of origin is usually Catholic or Christian fundamentalist. It is important not to conclude prematurely that the presence of demons implies Satanic ritual abuse; doing so could lead to confabulation pressure. This is also true of artwork: a patient treated to stable integration before I left Canada in 1991 produced what looked like classical Satanic ritual abuse drawings but never recovered any ritual abuse memories. The Satanic elements in the drawings were clearly derived from the Catholicism of her parents, who had emigrated to Canada from a Mediterranean country.

Deprogramming without Deprogramming

The best way to deprogram a person who has been a victim of systematic mind control carried out by a destructive cult is not to do any deprogramming. The programmers, if they exist in external reality, failed to incorporate two variables into their calculations: the creation of a dissociative-disorders field and the healing power of a therapeutic relationship. I do not refer to myself as a deprogrammer, because it makes the therapist sound like an artificial-intelligence expert, which to me has mechanistic and inhuman connotations. A case example will best make the point.

A Satanic ritual abuse survivor described forced participation in ritual murders up until two years prior to my working with her, including drugging and murder of hitchhikers in ceremonies, with her father receiving payment for delivering her and the hitchhiker to a secluded, wooded ceremonial site. The patient had a polyfragmented personality system with many subregions and subsystems, including alter personalities with names from Egyptian mythology. One of these had been programmed by the cult to commit suicide and was stating an intent to do this immediately upon discharge.

The host personality was very fearful of the 'programming' and requested an extended stay in hospital to work on her programming, which I declined by setting a fixed discharge date. The flaw in the logic of this system was twofold: first, that the programmed alter personality

was not a part of the self; and second, that the programming was a negative external influence inserted from the outside, with no systemic function. It is easy to get drawn into the system and lose sight of the fact that these are cognitive errors, which results in the therapist looking at the problem from the internal perspective of an alter personality.

Realizing that it was *the patient* who was suicidal, not another human being, I sought the systemic function of the programming model, which was easy to find. On confrontation, the programmed alter personality readily admitted that she was just holding the host personality's suicidal ideation, so that the host could disavow ownership of it, while maintaining a victim role which re-enacted her relationship with her external perpetrators. I reframed the programming myth as a helpful illusion for the host, looked at from one perspective, but emphasized that the cost of the strategy was never to be able to own and work on her self-destructive feelings. This intervention was remarkably effective, and there was no further talk of being victmized by the Egyptian alter's programming.

The potential for secondary gain inherent in the programming model is evident from this case illustration, because with really high-level programming, which is the most narcissistically gratifying to have and the most self-inflating to fight as a cult-buster, hospital stays of many months, or even years, can appear unavoidable. I have listened to conference tapes of MPD therapists differentiating high-level programmed patients from 'garden-variety multiples'; there is unwitting pressure exerted in such therapies not to be boring and garden-variety, and to confabulate sophisticated mind-control programming.

The best way to deal with programming is to understand its function and meaning inside the patient, to deal with the underlying psychology, and not to address the programming directly in any technical sense. When the necessary work has been done, the programming loses its power and evaporates. Whenever I hear about a therapy in which special hand signals, accessing codes, elaborate hypnotic induction rituals, excessive dependence on ideomotor signals, voluntary restraints, or other extraordinary techniques are required, I always suspect that the therapy is counterproductive. This is no different from being suspicious about a general adult in-patient practice in which almost every patient gets a course of twenty electro-convulsive treatments: the problem is not with the electro-convulsive therapy as such, which can be a humane treatment method, but with its misapplication.

Another problem with the deprogramming model is that it increases

the disrespect of skeptical mental-health professionals for the dissociative-disorders field. Since there is no essential reason to adopt the word 'programming,' because it carries no specific treatment meaning, even minor political costs of the term outweigh any possible benefits of retaining it. Many patients view their programming as literally and concretely a foreign entity inserted into their psyches, a cognitive error I attack through direct education and common sense.

Satan and Borderline Personality Disorder

The relationship between Satan and borderline personality disorder, as discussed in chapter 3, is interesting and complicated. Satan is the Christian mythical embodiment of the projection of the bad self outside the self, while in contemporary psychiatry, borderlines are usually objects of hostile, rejecting professional countertransference. Borderlines are usually female, and are the psychiatrists' demons, alternatingly lusted after and feared. Every psychiatrist who writes on sexual abuse of patients by psychiatrists agrees that the most common dyad is a middle-aged male psychiatrist and an attractive female borderline in her twenties (an Inquisitor and a witch). Most theories of borderline personality disorder are fundamentally dissociative, though the word 'dissociation' is scrupulously underutilized. Even in the writings of Gunderson and Sabo (1993) on borderline personality disorder, Gunderson being the borderline specialist who has most emphasized dissociation, dissociation tends to be a vague general concept for a group of symptoms and is not used in a structural sense.

The fundamental psychoanalytical features of borderline personality disorder are splitting, projection, and denial. By this, psychoanalysts mean that borderlines have not been able to integrate their positive and negative feelings about themselves and the world into a coherent, stable identity: they are split. They are therefore prone to violent, unmodulated oscillations from positive to negative states of mind. When in a positive state, they tend to see others through rose-coloured glasses, which is called 'idealization,' while, in a negative mood state, they view others as hostile, rejecting, and punitive, which is called 'devaluation.' 'Splitting' is also used to describe the way borderlines divide a treatment team into two camps, one aligned with the borderline's positive states in a nurturing, protective stance, the other hating and rejecting the negative states.

The projection comes into play when the feelings of the negative mood state are projected out onto others, so that, instead of the self being

bad, it is others who are bad, thereby reducing the borderline's self-loathing. The same occurs in the positive mood state, except that the other person is idealized and clung to instead of being rejected. The denial is the borderline's inability to see neither her violent oscillation from positive to negative states and back, with grossly inconsistent behaviour, nor the effect of this behaviour on others.

The causes of borderline personality disorder, in classical psychoanalytical theory, have nothing to do with severe childhood trauma, which is hardly ever mentioned in the classical borderline literature, but instead lie in subtle disturbances in early relationships with the mother. Anyone who has read this far in this book can see two things: (1) these are the fundamental structural characteristics of MPD, and (2) the relationship between God and Satan is being acted out inside the borderline. If we substituted 'dissociation' and 'partial amnesia' for 'splitting' and 'denial,' the similarity with MPD would be clearer. Is it any wonder that the borderline split as a child, when her parents acted towards her in a grossly inconsistent way, alternating between abusing and babying her? The difference between the borderline and the multiple is that the borderline's dissociated states are not personified to the same degree, and the amnesia between the states is less complete (Boon and Draijer, 1993).

Although, in principle, the psychoanalytical theory of borderlines is not punitive, in practice 'borderline' is almost always used to indicate that the patient is hostile, demanding, unpleasant, manipulative, attention-seeking, and prone to regression and dependency if admitted to hospital; in other words, the patient is a witch by *Malleus Maleficarum* criteria. The term 'borderline' functions to rationalize sadistic countertransference, and to legitimize rejecting triaging decisions within the health-care system. Actually, most of the time, in my experience, the splitting is coming from the staff, not the patient, and it is the mental-health professionals who are using projection and denial. This is an example of 'blaming the victim,' which is a fundamental borderline psychodynamic.

Within the mental-health system in North America, the borderline victim of severe childhood trauma is usually blamed for her behaviour, which is regarded as having no legitimate basis and being self-indulgent; her trauma history is ignored and not talked about; and she is given as little treatment and follow-up as possible. At St Boniface Hospital in Winnipeg, many staff members expressed the opinion, in my presence, that borderlines and multiple personality disorder patients did not have a legitimate right to in-patient treatment, and the out-patient

department would not accept patients with either diagnosis. This attitude is quite representative of that of contemporary psychiatry.

A case example will illustrate how I deal with the theme of borderline personality disorder, and the cognitive errors surrounding it, in Satanic ritual abuse survivors.

A patient was referred with eighty previous hospitalizations for borderline personality disorder, with MPD as a concurrent diagnosis over the previous five years. None of the in-patient psychiatrists in the hospitals available to her believed in MPD. The patient had an alter personality who claimed ongoing involvement in Satanic rituals, although it was unclear whether this alter was oriented to time and could differentiate the 1970s from the 1990s. This alter personality was at times combative, and always actively suicidal.

One of the problems in the case was the destructive programming to which the patient had been subjected: in this instance, the programmers were the in-patient psychiatrists, and the programming was a series of cognitive errors about borderline personality disorder. It was certain for the patient herself, and for staff, that her personal transactional patterns were heavily borderline, and that this was a serious handicap.

The patient had been told, and believed, that she was borderline, which was true, and that she was not multiple, which was not true. She was highly conflicted and ambivalent about whether she had real MPD, and whether her ritual abuse memories were real. She thought she might have an atypical MPD which nobody knew how to treat. Her personality system had little structure, and her personality states seemed to be created and then disappear soon after in a chaotic fashion, making it impossible to get any consistent internal work done. Gradually, a clear understanding of the problem emerged.

The patient had it in her mind that borderlines are borderline for no good reason, and that they get themselves admitted to hospital only for regressive, illegitimate purposes. The hostile professional countertransference towards her back home was transparently obvious, even given a considerable degree of distortion by the patient. In her thinking, if she was borderline, this meant that she was bad, a nuisance, had no trauma history, and was untreatable.

However, if she had MPD, she thought, she had a good reason for her problems, was not simply bad, and could hope for recovery. In this scenario, the bad self was projected out onto the non-believing psychiatrists, who identified with the projection and acted-out the hostility back on her. This elaboration of projection, in which the other person actually

experiences the projected feelings and acts them out against the person doing the projection, is called 'projective identification.' The problem was that the patient didn't clearly have MPD and a trauma history, although she was undoubtedly highly dissociative and met *DSM-IV* criteria for borderline personality disorder.

We worked hard to clarify the creation and substantial reality of the one alter personality we knew well, who was consciously brought into being to deal with childhood loneliness and modelled after a specific character in a book. We used this as the starting-point to establish that she definitely had one alter personality, and therefore had MPD. Next, we examined a related clinical problem – namely, that she was unable to uncover and process traumatic emotions, even when she could recount a historical narrative concerning the traumatic events. One possibility was that she had no feelings because the events never actually happened; therefore, her inability to get her feelings back did not represent being stuck in therapy.

It turned out, on further analysis, that any time she began to recover any feelings at all in therapy, she became internally disorganized and suicidal, and was sent to hospital for a borderline-crisis admission. The hospital environment was so punitive and unpleasant that, within a few days, she would decide to shut down emotionally in order to get out, would reconstitute, and then go back home no farther ahead – a cycle repeated literally eighty times. Based on circumstantial clinical evidence, I hypothesized that she had a group of alter personalities that could not tolerate the traumatic feelings, and who deliberately made her suicidal and disorganized in order to get admitted, knowing full well that the hospital would be so aversive to her that she would shut down in order to get discharged.

I reframed this behavioural cycle as a positive attempt to keep the system from getting uncontrollably flooded with traumatic emotions, reviewed its logic with her, and suggested that she abandon the goal of forcing feelings to come out in therapy before her alters were communicating and cooperating with each other. I pointed out that the psychiatrists defining her as a dependent bad borderline with no childhood trauma history helped to shut the system down, and therefore were playing their role in the psychodrama correctly. If the psychiatrists defined her as having MPD, they might want to open up her system and flood her with emotion, the very thing her alters feared. Therefore, the more she could not look like MPD and not get any benefit from MPD therapy, the better.

Another part of the intervention was to educate her about the traumatic foundations of borderline personality disorder, and how it is basically a partial form of MPD. This being so, there is no real dichotomy between the two categories, and borderline personality disorder can be as legitimate and trauma-based as multiple personality disorder. This meant that she could work on her borderline issues and have a trauma history, a solution to a bind which had prevented her from doing productive work on her borderline cognitive errors and transactional patterns. It also meant she didn't have to have 'regular' MPD in order to have hope of recovery, because the different diagnostic possibilities were all points on the same trauma–dissociation spectrum.

Also, she was liberated from having to dig for buried emotions in therapy: this had previously been defined as the legitimate work that people with MPD do in therapy, and therefore, by not doing it, she was being a bad borderline instead of a good MPD. There were a number of other twists, turns, and permutations to the logic, as there are in the history of Satan. In this case, there was no alter personality named 'Satan' in the system, only because she did not happen to have utilized that particular elaboration of her internal structure: the psychodynamics of Satan were none the less all present.

I gave this woman a lengthy dictated summary of my analysis, and some reading on the cognitive therapy of borderline personality disorder. She left hospital optimistic about her future: now she could work on her borderline personality disorder, which gave her hope and legitimate status as a patient in her own mind. This perception was not unrealistic: she had corrected the cognitive errors of twentieth-century psychiatry, which had been projected into her by mental-health professionals at home, a projection she readily absorbed because of her high hypnotic and dissociative capacity.

The Presenting Problem of Suicidal Ideation

As described in chapter 9, on our Dissociative Disorders Unit we take a problem-oriented treatment approach, and the most common presenting problem is suicidal ideation, often accompanied by superficial cutting, and burning with lighters or cigarettes. Although, strictly speaking, the ideation is not literally suicidal, it is certainly self-destructive. A clinical case of a woman with Satan and a demon inside, who had been cutting and burning on herself for some time, illustrates how I deal with this

problem in Satanic ritual abuse survivors, although this particular woman had never been ritually abused.

This case highlights a number of points, one of which is how hopeless the situation appears to be when you first get into the system. In the information we requested of her before hospitalization, Debbie said that her treatment goal was to kill the demon inside her and get rid of Satan. She felt that she literally had a demon inside her, and that it would be better for her to kill herself than let the demon come out, which would probably result in the demon sexually abusing children. The demon had been abusing her internally for years, she felt. She also had Satan inside; he was even more powerful and suicidal, and controlled the demon.

Debbie was horrified when I suggested that I would like to get to know Satan directly and talk with him. Also, she could not comprehend my insistence that the demon had to stay in behavioural control while she was in hospital, or why assaultive behaviour might result in immediate discharge. She was incredulous that we wanted her to control the demon's behaviour; she felt she had no power over it and that it had been controlling her for years. No matter how many times I explained that we were not asking her to control the demon but were asking the demon to control himself, she could not grasp the concept, and she thought it unfair that she should have to experience the consequences of the demon's behaviour. Debbie had the MPD delusion of the separateness of parts of herself to the most extreme degree possible: not only were parts of her not herself, they were not even human.

Satan was calm and rational when I spoke with him directly at length during my first interview with Debbie. He explained that he had been inside Debbie since childhood, and that he enjoyed, and, in fact, caused, the incestuous sexual abuse she experienced as a child. Not only had Satan been inside Debbie, he had been directly controlling the perpetrators and making them perform the abuse. Additionally, he had deliberately injected some of Debbie's father's spirit inside her in the form of the demon, in order to maintain better control over her. His plan was to make her kill herself so that she could join him in Hell, where he would have complete control over her.

I began my attempt to help this woman by directly explaining to Satan and Debbie, who were co-conscious for this interview, that I did not believe it was literally Satan inside and that, in my experience, Satan usually turns out to be a traumatized child. Then I explained the logic of having Satan inside, reviewing my belief that the primary reason to have Satan inside is to gain a sense of power and control in a situation devoid

of real power. I explained that the illusion that Satan was in control of the perpetrators was a creative and protective illusion, but an illusion nevertheless, and that really what was happening was the horrifying and painful sexual abuse of an innocent child. I said that the reason Satan needed an elaborate internal landscape to hide in was in order to protect himself, and pointed out that, if he was really Satan, he wouldn't need such protection.

Because Debbie had described Satan as angry, I also talked about his anger, saying that he had every reason to be angry because of the abuse. I praised him for doing the difficult job of holding all of Debbie's anger over the years so that she could be the perfect little Christian girl who never got angry and always wore a clean dress. I also asked Debbie to consider how it must feel to perform such a difficult and unwanted service for so many years and then be hated and rejected as Satan. When she protested that he really was Satan, I reviewed the fact that, if the illusion wasn't complete, it wouldn't work; therefore, it was essential to believe completely. It was good to have Satan inside, because that helped her stay good and prevented her from being further abused for displaying unChristian anger in the home. It was, in fact, a very good and Christian thing Satan was doing for her by being Satan inside.

When I said these things, Debbie responded tearfully and with resentment, saying that I was taking Satan's side and that I didn't understand he really was Satan. I changed tack in response, and pointed out that I had just finished a conversation with Satan in which I said that his destructive behaviour towards the body was completely unacceptable and had to stop and that I therefore was not simply taking his side. Satan felt that I really regarded Debbie as my patient and just wanted to get rid of him, a cognitive error I reframed for him by explaining how Debbie had been prone to abuse in adulthood because she could not tap into his anger and toughness, and that the goal of therapy was to have her accept him, and for them to be closer together, rather than to get rid of him.

A turning-point for Debbie came when she was describing what appeared to be a combination of a trauma memory and an internal waking nightmare. She described a situation in which her three family perpetrators were coming towards her with abusive intent, but their eyes were glowing red and shining like flashlights. She thought she might be in the basement, and was terrified at the men's approach, when suddenly a similar pair of red eyes emerged from hers and moved out in front of her, and she went into the background and blanked out. I asked

her whose eyes she thought those might be coming out of her, and she said she had no idea. With some prompting and leading questions she suddenly exclaimed, 'You mean it was Satan?'

In subsequent sessions, Satan confirmed that he had come out to take considerable abuse for Debbie, and confessed that he wasn't really Satan, wasn't really in control of the perpetrators, and didn't know exactly where he came from or how he got into Debbie. With these corrections of the cognitive errors in the system, the increase in interpersonality communication and cooperation, the reframing of the persecutors' actions as positive in intent, and the reidentification of Satan as a part of Debbie created to help deal with the childhood trauma, the presenting problem gradually resolved.

Another case illustrates related logic in which a parent or perpetrator is one of the alter personalities inside, a common feature of MPD systems based on the defence mechanism of 'identification with the aggressor.' In this case, the patient's deceased mother was inside, keeping the system shut down, and was trying to talk the patient into killing herself so that she could join mother in God's peace and rest on the other side. The mother alter had declared herself in therapy when well-planned, controlled memory recovery was begun with the consent of all the known alters, at which time she put them all to sleep inside, except for the host. The patient did not want to join her mother in death.

The clue to the key cognitive error in this system was a missing letter *s* in a note written by the mother alter to the host. The mother was talking inside, acting, and writing as if she was literally the mother, a fully separate human being. Her slip was to refer to their *soul*, singular, resting in heaven with God. If she had written *souls*, I would have had more trouble opening up the system for productive therapeutic work. I jumped on this error immediately, and made use of her strict Southern Baptist background to make two points: (1) people who commit suicide cannot go to Heaven, which would be the outcome for both mother and daughter if they have one soul; and (2) people who commit murder cannot go to Heaven; therefore, if they have two souls and mother kills daughter, they cannot join each other in Heaven. The suicide was conceptualized by the maternal-introject alter as a mercy killing.

Additionally, I argued, the killing could not really be euthanasia because the daughter was not consenting, was, in fact, actively protesting; therefore, I could only conclude that the motive for the killing was not the best interests of the daughter. This, in turn, must mean that the motive for killing the daughter was to protect interests of the mother,

and I speculated out loud to both of them that the possible motives were: the mother's fear that, if the daughter remembered, she would hate her; and the mother's ongoing commitment to keeping the family secret. The daughter reassured the mother that she would always love her.

This analysis was an important factor in the mother alter personality forming a treatment alliance, allowing the rest of the system to wake up, and consenting to a planned piece of memory-recovery work in less than a week. As a result the presenting problem of command hallucinations for suicide resolved. This case illustrates the 'mouse gnawing at cheese' model of cognitive therapy, in which the therapist picks away at the system, searching for a key cognitive error whose correction will decisively open up the system and turn it towards recovery. When I am working in this mode, I direct relentless questioning at the patient.

In another facility, Debbie could easly have received a diagnosis of paranoid schizophrenia, with command hallucinations and a delusion of hearing her dead mother talking to her.

Alter personalities believed to be literally the dead father/high priest from the cult are common in Satanic ritual abuse survivors, and often the father will claim that he is a psychic intrusion from Hell who controlled his daughter and was inside her psychically before he died. Forming a treatment alliance with the hostile introjects can be difficult, but one strategy is to appeal to their narcissism. The fathers inside often consider themselves to be sophisticated builders of multiple personality disorder in cult children, and view their daughters as pet science projects and testaments to their expertise.

With one such father, I said that any run-of-the-mill high-school dropout alcoholic could create MPD in his daughter by sexually abusing her (the father had been an advanced-degree professional). Deliberately using the vernacular, I said that creating an MPD daughter, and having her flame-out in suicide, prostitution, or heroin addiction, was a dime-a-dozen achievement, but a *real* science project was one so intricately and exquisitely designed that it could be fully dismantled while leaving the organism intact and undamaged. *That* would be evidence of high-powered progamming, I said, and I suggested to the inside father that, since he had so much expertise about the creation and structure of the system, he could monitor and supervise the dismantling internally far more effectively than I could from the outside.

A subchallenge I gave this inside father was an offer to raise his daughter's privilege level, an essential step towards discharge, in return

for a good-faith demonstration that he could shut off a severe compulsive symptom she had had continuously for years. This compulsion had been treated with high doses of fluoxetine and months of in-patient work on another dissociative-disorders unit with no effect. For the first time in years, there was absolutely no sign of the compulsive behaviour for three consecutive days.

The next bargain was to shut off the continuous high level of suicidal ideation in return for another level increase. This woman had been in hospital for seven months the previous year, and was described by experts in dissociation with PhD and MD qualifications as the most suicidal multiple they had ever worked with. I made use of the failure of this high-powered expertise as evidence of the inside father's power and counter-expertise, and defined the shutting-off of the suicidal ideation as a good joke on the mental-health care system. The initial joke of looking like the most suicidal patient anyone had ever seen, when she wasn't actually suicidal at all, was funny, I said, but consider the hilarity of demonstrating that the suicide compulsion is under *complete* conscious control and can be shut off at will! Now *that* would be funny!

The inside fathers have been integrated, and the suicidal and other compulsions have been in remission without medication or further psychiatric in-patient care, for over a year. The patient achieved initial complete integration in 1994 and had not relapsed as of early 1995. As a single-subject experimental design, this is a powerful demonstration of treatment efficacy.

The Presenting Problem of Post-Traumatic Hyperarousal

About 70 per cent of the people admitted to our unit meet structured interview diagnostic criteria for post-traumatic stress disorder (PTSD). The remaining 30 per cent also have a form of PTSD by definition, since MPD is a chronic post-traumatic disorder of dissociative type, with an onset in childhood. The common symptoms of PTSD that we see include hypervigilance/hyperarousal symptoms, which involve being tense, keyed up, fearful, easily startled; always scanning for danger; being unable to get to sleep; being prone to nightmares; exhibiting intrusion/revivification symptoms, such as flashbacks and trauma nightmares; being suddenly reminded of past trauma by triggers in the environment; episodes called 'abreactions,' in which past trauma is relived intensely as if it is reoccurring in the present; and exhibiting constricting/numbing symptoms that involve being shut down emotionally or numbed

out. In this section, I focus on the hyperarousal symptoms rather than the numbing.

A patient may be admitted with suicidal ideation or self-destructive behaviour, but we may decide in consultation with her that the most disturbing symptoms are the PTSD ones, and we may assess the suicidal thoughts as being secondary to the intolerable level of hyperarousal. The treatment task is then to close the system down to a more tolerable level, which will permit ongoing out-patient function while continuing productive therapy.

Assuming there are no obvious medical problems such as hyperthyroidism contributing to the clinical picture, two immediate interventions may be helpful. We might try to reduce the amount of stimulation the survivor is experiencing, which might be done by having her sleep in another, quieter unit or having her avoid certain stimuli in the hospital temporarily. In addition, we would probably prescribe a benzodiazepine such as clonazepam or lorazepam in fairly high doses, with a plan to taper the dose down as the problem comes under psychotherapeutic control. A typical order for lorazepam might be 4 mg by mouth or needle up to three times a day on an as-needed basis. Additionally there might be a fixed prescription for 2 mg by mouth three times a day, to ensure a minimum level of control. The amount of medication prescribed can be varied according to need in a number of ways.

The next step is to get into the personality system and analyse the problem psychologically. Usually a hyperaroused patient has too many memories coming back too fast, or a major memory in the process of coming back. The initial treatment plan might read like this:

1 Decrease environmental stimulation initially.
2 Medium to high dose of benzodiazepines.
3 Map system; identify key alters involved in the returning trauma memory.
4 Increase interpersonality communication and cooperation.
5 Contract with controller alter for reduced rate of trauma-memory recovery.
6 Create a safe place for traumatized child alters.
7 Establish a method for slower memory recovery post-discharge.
8 Three-week admission.

The returning trauma memory likely has been partially recovered by the host personality already, which is why the host is experiencing trau-

matic symptoms, so we first clarify what it is that has been remembered so far. One can assume that the memory is probably held by child alters who are upset, disturbed, and causing a commotion internally, and usually there will be a persecutor who is stimulating the memory return to sadistically torment the host and/or is annoyed by the hyperarousal of the children. In a Satanic ritual abuse case, the persecutor is often a demon or the cult father.

The next two steps are to soothe the children and form a treatment alliance with the persecutor. One of the best ways to create a working relationship with the persecutor is to talk about discharge, since the persecutors always take the opening stance that they hate being in hospital and want out immediately, and usually state that they plan to kill the host as soon as possible.

I will point out to the persecutor that the suicidal threats, excessive memory flooding, and PTSD symptoms are, in fact, keeping him in hospital, and therefore a reduction in these symptoms is required for discharge. Also, I discuss the fact that, since our average length of stay is three weeks, I really am committed to discharge as early as possible. I suggest to the persecutor that he and I work towards the same goal, and then begin to propose specific changes in the system that will facilitate this goal being reached. Usually, the underlying problem is that the persecutor is being flooded with intolerable feelings because of the hyperarousal of the children, though he can't admit it because of the evil, sadistic façade he is presenting.

I next propose to the persecutor that, if he agrees to slow down the rate of memory recovery, I will help build a safe place for the children inside, where they can rest, sleep, and be quiet. This, by itself, reduces the hyperarousal flooding into the host and the irritation of the persecutor. The evil demon may decide that having a safe place is advantageous, and may then complain to me that he is being left out, while the children are getting extra attention, to which I respond with an offer of a safe place for the demon.

Although it usually takes some time, the demon may eventually take off his job suit and agree to function as an adolescent supervisor of the children, which might involve reading them bedtime stories. If the children can be put in a comfortable dorm inside, and read soothing bedtime stories, this will reduce the host personality's insomnia and nightmares. The principles and timing of these interventions are no different in a Satanic ritual abuse case than in non-ritual MPD, and only the content of the memories varies.

Once all these structural and functional changes to the system are in place, the presenting problem is usually under good control, and discharge not far away. A remaining task is then to undertake a limited piece of trauma-memory recovery, to demonstrate to the system that it can do this work at a painful but tolerable pace. This will desensitize the system to the process, and give it an experience of mastery to contrast with the preadmission uncontrolled flooding. Usually the memory work will involve recovery and processing of the remainder of the partially recovered memory which caused the admission.

The patient will be taught a number of skills and techniques for memory work that are summarized by the technical term 'fractionated abreaction.' Over the previous ten years, the dissociative disorders field has learned that pacing of memory recovery is very important and has realized that the work must not be done too quickly. Many patients still believe that memory recovery is the core of therapy, and that remembering horrifying abuse in and of itself leads to recovery: this misconception needs to be corrected. Part of the cause of the PTSD symptoms can be pushing for memories too fast because of insufficient understanding of the therapy process.

Fractionated abreaction is a process in which the memory is recovered in stages at a controlled rate. I will not review all the techniques here, but it can involve playing the memories on an internal movie screen without the feelings, then allowing the feelings to surface later; controlling the intensity of the feelings with an internal rheostat; going into the memory for a finite, prearranged period of time, and coming out in a controlled fashion in response to a cue from the therapist; time-distortion techniques; and other methods. The basic idea is to use the hypnotic and cognitive skills of the patient to break the memory up into controlled portions or fractions, so that it can be recovered piecemeal without flooding and decompensation. It can be very helpful to have an internal protector hold, soothe, rock, comfort, sing to, or otherwise care for the children during the memory work.

I am finding that I do much less abreactive work in therapy as I gain experience: the memory work now involves simple conversation and recollection, and very rarely an abreaction with screaming, hiding in the corner, dramatic clutching at the vaginal region, or full immersion in the past as if it is happening over again in the present. This fully opened-up method of memory work seems not to be necessary, and to be retraumatizing. My abreactive work has been modulated down to the level of intense recollecting, for the most part, though patients still do some full

abreactions during sessions. A patient who recently reached initial integration in my practice didn't do any full abreactions in therapy, although these happened spontaneously at times outside sessions.

Opening Up or Shutting Down?

Two patients admitted to a dissociative-disorders unit may have treatment plans which go in opposite directions, or both directions at once. Like most things in the psychotherapy of Satanic ritual abuse survivors, no one standard approach applies to all cases, although there are general principles. The question is, how to decide whether the emphasis should be on opening up or shutting down? Usually this turns out to be relatively straightforward, since it is obvious whether the survivor is too opened up or too closed down.

A surprising lesson I have learned from working with survivors is that it is possible not to be borderline enough. It turns out that the most difficult patients to work with, the ones who make the least progress, are those who are passive, avoidant, and shut down. It is very hard to get into their systems and do productive MPD work, and one gets stuck at the level of chronic characterological problems. In these cases, the character structure is masking the MPD system and interfering with the work of therapy; therefore, the challenge is to open the system up. When the character style is pervasive throughout the system, rather than limited to the host personality, the work can go very slowly. We try to get such patients to be more volatile, reactive, and uninhibited, which means more 'borderline.'

More commonly, the system is too opened up, and our task is to close it down, as described in the previous section. In deciding on our treatment plans, we always face a tautological problem of whether the borderline features are primary or secondary to the MPD. In cases in which the manifest borderline personality disorder is structurally attributable to the MPD, we ignore it, except for basic unit limits and guidelines; avoid power struggles; and focus on the MPD system work: in such cases the borderline personality disorder goes into remission as the survivor reaches integration, and she is not borderline post-integration.

In other cases, though, the borderline issues seem to be primary and predominant, and the person as a whole is functioning as a borderline, with all the annoying, negative behaviours the diagnosis implies. In these cases, we cannot deal effectively with the MPD because the borderline psychodynamics are overriding the system and dominating the

clinical picture. Our assessment of the mixture of these two extremes in a given case will affect the decision as to whether to open up or shut down. In the patient who is being driven by primary borderline psychology, it would be countertherapeutic to recover more trauma memories, because that would destabilize her. In another case, the opposite would be true, and a controlled piece of memory work would dramatically reduce the amount of borderline behaviour.

One of the techniques for opening up a patient is a sodium amytal– or barbiturate-facilitated interview (sodium amytal is the truth serum of television and movie fame). I discuss sodium amytal briefly as an MPD therapy technique because my enthusiasm for it has declined since I wrote my text (Ross, 1989). Sodium amytal is a barbiturate like those used for anaesthesia, and it appears to work by anaesthetizing the patient's inhibitions, allowing memories to come flooding back. The memories recovered during a sodium amytal interview can be real, confabulated, a mixture of the two, or deliberate lies, so it is important to understand that there may be no truth in the truth serum.

With accumulating experience, my enthusiasm for sodium amytal has declined for several reasons. One is that the post-interview course is too often behaviourally out of control for twenty-four hours, with agitated behaviour, attempts to elope from the unit, head-banging, dramatic falling, cutting, and theatrical behaviour in front of the nursing station. This happens because the person has become acutely hyperaroused by the breach of her dissociative defences and by flooding with horrific memories. Too often this behaviour sets off a chain reaction in the other patients, so that already overtaxed nursing staff have to cope with four or five simultaneously abreacting and out-of-control patients. The interview then has been destabilizing for both the individual patient and the unit. Too many events like this cause burn-out among the nurses and lead to resignations.

Additionally, the interview often implies an adversarial relationship with alters inside who are trying to block memory recovery, and therefore undermines any treatment alliance with them, making ongoing outpatient work more difficult. Patients can demand sodium amytal just because they enjoy the high, and can then get caught in a positive-feedback loop, in which they reward the therapist with new memories only if they get drugs. In this situation, one would expect the creation of extreme confabulated Satanic ritual abuse memories, and it is usually ritual cases that have the most difficult post-interview courses.

Another internal dynamic is that the intoxication with sodium amytal

becomes a re-enactment of abuse during which the survivor was drugged. When this is the case, some alters will have intense abreactions which are purely retraumatizing, and they will likely fear that the hospital is a cult hospital, with ritual abuse by staff imminent. A number of different cognitive errors, conflicts, and misperceptions within the system can cause a negative reaction to sodium amytal, and patients who demand it are often trying to avoid the necessary system work. Requests for sodium amytal most often come from patients who are addicted to being too opened up, and rarely from those who are too shut down.

The concept of a sodium amytal interview is rather odd. There is probably no chemical specificity to sodium amytal, and any barbiturate, benzodiazepine, or form of alcohol would probably work as well. A sodium amytal interview is like getting drunk: would a psychiatrist recommend that a patient get drunk in order to get better control over her behaviour and recover accurate memories from thirty years ago? Hardly.

I have reviewed the negative apects of sodium amytal interviews because I think they have been underemphasized. Sodium amytal can also contaminate and invalidate a case that goes to trial in the current legal climate, and opposing expert witnesses will make a great deal of it. Although such interviews can be helpful in selected cases, they should not be used too often and, in the current insurance and medico-legal environment, can probably, for the most part, be replaced with oral or intramuscular barbiturate or benzodiazepine interviews. It is essential that the problem of whether to open up or shut down is considered in all its permutations in any decision about barbiturate-facilitated interviews.

The Presenting Problem Is Not the Problem

A vignette serves to illustrate the core principle at work in a non-Satanic cult ritual abuse case: the patient alleged that she had been ritually abused by her father in a KKK/neo-Nazi/right-wing supremacist cult. Her main problem was that her husband's hair was too short. Her suicidal ideation was secondary to the fact that her husband was refusing to grow his hair longer. The preoccupation with her husband's hair length was fixed, obsessive, and unrelenting, and she could likely have benefited from a serotonin re-uptake inhibitor like fluoxetine (Prozac). As is true for depression, however, her problem was treatable with cognitive therapy.

Enquiry established that she thought her husband was also involved in a neo-Nazi cult, the evidence for this being that two years earlier he

had cut his hair short. In her mind, short hair equalled skinhead equalled neo-Nazi equalled abuse perpetrator: to break this equation and feel safe, she needed to force her husband to grow his hair longer. This was only a facet of her attempts to take rigid control of her environment to prevent a catastrophe which in fact was never going to happen. Psychoanalytically, her defences were obsessive, were based on magical thinking, and involved an attempt at undoing the powerlessness she had experienced during the childhood abuse.

My first intervention was primarily psycho-educational and involved a review of the behaviour we would expect from someone who actually belonged to the Nazi Party, as she thought her husband did. She confirmed that he possessed no Nazi paraphernalia, uniforms, pictures, or other materials; never espoused right-wing supremacist doctrine; never made anti-Semitic remarks; and did not appear to be attending any kind of deviant-group meetings. On questioning, she also confirmed that he used to beat her on a regular basis when his hair was longer but had done so only twice since cutting his hair short.

I pointed out to her that, since her husband clearly wasn't a member of the Nazi Party or any neo-Nazi organization, the question was why she was holding onto a belief that was so obviously false. What function was that false belief serving for her? In addition, I pointed out that, in fact, he abused her less when his hair was shorter, so forcing him to grow his hair longer wouldn't make her safer in the present. What was going on, then?

It was evident that, in her childhood, she had learned to equate short hair with sexual perpetrator, and that she was trying to undo this equation; but an unaddressed question was why, if her husband was still physically abusive, didn't she get a divorce? The answer was clear and commonplace: the patient was afraid that, if she confronted her husband directly about the physical abuse, he would either beat her more or leave – either way, divorce would ensue. This, she feared, would result in her and her children losing their acreage and home, and being destitute, since she felt she was unemployable and without marketable skills. Better, then, to retreat into magical thinking and focus obsessively on trying to control her husband's hair length to create an illusion of safety.

The real issue in the case was the standard dilemma of the battered wife, and the cult material was a red herring. For her to be engaged in a real therapy, with real hope of recovery, it would be necessary to focus on her current problems, rather than working at the level of magical thinking or deprogramming her 'short-hair programming.'

The Satanism Can Be a Cover for Mundane Daily Problems

A patient was admitted to our unit for active suicidal ideation and homicidal ideation directed at her husband. She reported that her Satanic alters had almost stabbed him to death with a kitchen knife during the night, and that the murder had been prevented only by an active effort to regain executive control on the part of her Christian alters. The couple were fundamentalists. As in the previous case example, the Satanic motifs were a cover for mundane, but serious, marital problems.

With drama and sexual provocativeness, the patient described her role as a high priestess in Satanic human sacrifices and the repeated near-murders of her husband. The problem was that the Satanic alters hated him because he was Christian, she said. When I spoke directly with the Satanic high-priestess alter, however, she gave a slightly different account of the problem. The husband, she said, was a pig who left his dirty laundry on the floor for the host to pick up and wash. The Satanic alter was furious at the husband for his slovenly habits and chauvinist attitude, and at the host for her Christian dutifulness and servitude: the high priestess believed in the equation of Christian wife with domestic slave and had no idea that this equation is not intrinsic to Christianity.

In subsequent conversation with the host personality, who had been co-conscious for the discussion with the high priestess, the host admitted that she did feel mild exasperation at the husband. The problem was twofold: she perceived these feelings as anti-Christian, and she had absolutely no anger-management skills. She therefore instantly diverted her anger to the Satanic alters, who immediately escalated it to an extreme degree. The treatment of this problem did not involve attempts to convert the Satanic alters to Christianity. Instead, the focus was on desensitization to anger, acquisition of anger-management skills, validation of the patient's right to equal partnership in the marriage, follow-up marital therapy, and attempts to increase system communication and cooperation, while defining the Satanic rage as out of proportion to the current situation, but nevertheless valid. The only way the Satanists knew to handle things was to escalate them up into high-level hysteria, which never solved the problem since the husband never got murdered and never began picking up his socks. Whether the patient ever actually picked up a knife at home was important in terms of duty to warn the husband but did not otherwise affect the treatment plan.

In another case, a male patient described how his cult alters were 'sabotaging' his life and his therapy, while he dutifully worked and

supported the system. As always, the demons had another viewpoint. When I spoke with one directly, his chief complaint was that he was tired of doing the dishes all the time. The demon described how the host personality felt that, since he did the job, he could abandon executive control on arriving home, leaving the cooking, dishes, housework, paying of bills, and other domestic duties to the rest of the system. They were tired of being domestic slaves and simply wanted a reasonable division of labour.

The host personality, who was amnesic for this discussion with the cult alter, was astonished to hear the nature of the demonic protest and agreed to work on a more equitable deal. The other patients in the cognitive therapy group were both incredulous and amused when I said to the host that only a Satanist would ever complain about doing all the dishes.

Satanic Ritual Abuse Accounts That Are Psychotic and Delusional

The following case example illustrates that some individuals reporting involvement in Satanic cults are psychotic; an unskilled therapist might try to treat such individuals with memory work, or other psychotherapeutic methods that would not be beneficial and might be harmful. The case provides another example of how the treatment of Satanic ritual abuse cases should be based on general principles accepted in the mental-health field at large.

A teenager was referred by his high-school guidance counsellor for assessment because of a number of interrelated problems. His grades were slipping, he was becoming more isolated at school, his relationship with his parents was strained, and he alleged that he was involved in a Satanic cult along with a number of other boys at his school. The guidance counsellor was pretty sure that the Satanic cult did not exist but wanted an opinion from me (the consultation took place in 1989).

The young man told an elaborate story of being involved in a Satanic cult that met in the woods and was connected to the Temple of Set; there was no human sacrifice, but girls were lured to the site for sex. He said that the cult was often infiltrated by the local police, and then described how police undercover agents were detected: suspected individuals were pinched to estimate their percentage of body fat. Since it is well known that police officers eat a lot of doughnuts, he said, a high body-fat ratio confirmed that the person was an undercover police officer. The policeman would then be run off the site. He also stated that he was able

to walk through walls because of the power he had acquired from the dark side.

In addition, he told an even more elaborate story about being at a summer cadet camp in another province and being flown back to a town in northern Manitoba in a military jet for a large Satanic ritual involving people from many different places. The cover story for his absence from camp, he said, was fake medical records for an admission to a hospital for the flu. When I questioned him on the logistical details of how all this took place, he could not maintain a coherent account.

The young Satanist was also possessed. At my request, the entity inside him, named 'Damien,' took executive control and told me about his Satanic powers, control over the patient, and dedication to Satan. When I asked for the host identity to come back, he was partially amnesic for my conversation with Damien but impressed by it. He wore a skull's-head ring, and showed me some of his writings, which were a pastiche of biblical references, pop Satanism, and Egyptian mythology.

The treatment of this case did not involve anti-psychotic medication, although I seriously considered a trial of medication. With support from his school counsellor, meetings with his parents and the counsellor, redirection into healthier pursuits, and a return to active participation in his church, he experienced a spontaneous remission of his psychosis. Whether there was a drug-induced element to which he would not admit, I was not sure. On follow-up interview, he dismissed the period of belief in the Satanic cult and his possession by Damien as unreal and a result of his mind being 'mixed up.'

Conclusions

I have reviewed the diagnosis and treatment of Satanic ritual abuse survivors in this section to assist therapists treating this population, and because the general public, and those who debate the reality of Satanic cults, have little idea of how good therapy is done and what it involves. The debate about Satanism often occurs in a clinical vacuum that parallels the lack of a historical and social context, with no understanding of the principles of sound therapy. Charges about the negative effects of therapy for Satanic ritual abuse survivors with MPD should be tempered by an understanding of the strategic complexity of such cases, which would severely tax any mental-health professional.

The specific techniques used in the therapy of Satanic ritual abuse survivors with MPD are adaptations of techniques used in the treatment of

non-ritual MPD, which are, in turn, grounded in the principles of good generic psychotherapy. A therapist who uses too many special techniques in such cases should be viewed with suspicion. It is important to understand that a simple-minded formula for focusing on day-to-day problems will not work in the majority of Satanic ritual abuse cases. The most likely results of direct statements that the memories are confabulated will be self-mutilation and withdrawal from treatment. If the memories are regarded as confabulated, it is essential nevertheless to treat them respectfully as defences against intolerable conflicts and feelings. The treatment of a complex Satanic MPD case involves a subtle finessing of the patient out of confabulations developed over a period of years.

IV
Society's Response to Satanism

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Extremes of Skepticism and Denial

The sociology of the debate about Satanic ritual abuse is similar to that of the abortion debate, though on a smaller scale, and is a permutation of the psychology of Satan. Many parties to the debate, on both sides, are not studying the problem in a scholarly, academic, scientific, or disinterested fashion; rather, they are speaking from preconceived ideological positions. A sociologist who specializes in urban legends will say it's all urban legend, a fundamentalist Christian who performs exorcisms will say that Satan is stalking the land, a therapist who believes survivors as a matter of policy will believe it is all real, and so on. None of these positions is helpful in the planning of therapy, and all are excessively focused on the question of the external reality of Satanic ritual abuse.

On the believer side, one hears arguments that, because the survivor has body memories, the ritual abuse must be real. Such statements are scornfully dismissed by skeptical psychiatrists as the typical näivety of undertrained professionals. It is as if each side is setting up the other in a way which maintains the system's status quo: both skeptics and believers take such extreme and overgeneralized positions that they appear ridiculous to each other, thereby justifying entrenchment of each position. Thus the 'debate' goes on with no one changing position and little or no empirical data being gathered.

In this respect, the debate about Satanic cults is like the debate about abortion: in both forums, no one changes position, the quality of argument is often low, and each side is trying to overpower the other by political force. This polarization about Satanic ritual abuse is going to be played out in the courts over the next decade, with expert witnesses from both extremes making dogmatic statements which go far beyond

any available data or scientific knowledge. In this secular war between believers and skeptics, careers, reputations, therapies, and retirements will be ruined, with no advance in real understanding.

The arguments that are advanced are often intellectually dishonest. For instance, a skeptic will argue that the claims of therapists treating Satanic ritual abuse cases are not supported by any adequate treatment-outcome studies and will then call for caution by believers. This seems reasonable, but the skeptic actually uses the absence of outcome data as an argument *against* the sociological reality of Satanic ritual abuse, when the absence of outcome studies is, in fact, neutral with respect to questions of sociological reality. The absence of outcome studies documenting a successful treatment for AIDS has never led anyone to conclude that AIDS doesn't exist.

The skeptic will then go on scornfully to dismiss the therapeutic practices of believers, stating that they are harmful and regressive, and will then dogmatically insist that the treatment should be done his or her way. The problem is that there are no data to support the claim that the believer's therapy is regressive, and no data to support the efficacy of the skeptic's approach. This being the case, it is evident that the skeptic is not really interested in weighing the arguments.

In order to conduct balanced therapy, it is essential not to be pulled out too far into skeptical non-belief; to assist therapists in this regard, this chapter undertakes to counter the position of the extreme skeptics.

Psychiatrists' Claims That Mental-Health Professionals Treating Ritual Abuse Survivors Are Unscientific and Undertrained

I have heard psychiatrists and psychiatric residents state, with amused superiority, in private and in public, that the explanation for Satanic ritual abuse hysteria is the fact that undertrained, non-medical therapists are doing all the therapy. The first time I heard this said was in 1985, when I had just completed my training, though the speaker was referring to the treatment of non-ritual incest. The irony, from academic psychiatry's point of view, is that the most difficult psychotherapy cases are being treated by the least qualified and least supervised professionals, such as social workers. These therapists have not been trained in scientific, critical thinking, and therefore are likely to mismanage their cases. This viewpoint was entrenched in academic psychiatry before either Satanic ritual abuse or False Memory Syndrome entered public awareness.

Early in my training, I more or less agreed with this viewpoint, since it appeared to be a simple fact that social workers had less training and less background in the sciences than did psychiatrists. My misperception of the issues was fostered by the fact that, during my training, I had no extra-hospital contact with therapists treating sexual abuse patients so had no exposure to corrective criticisms by them. Gradually, a different view of the situation was forced on me by my experience.

I realized several things. First, it is almost impossible to get the majority of academic psychiatrists to treat even a single incest survivor with specific psychotherapy. Most academic psychiatrists treat predominantly light neurotic cases in their private psychotherapy practices, I discovered, and have little or no experience in the long-term psychotherapy of chronically mentally ill patients with serious Axis I disorders. Additionally, it is almost impossible to get the majority of academic psychiatrists to be the primary treating physican on a long-term basis for someone with schizophrenia. I was very surprised to learn in my training that only a tiny number of patients with severe mental illnesses have academic psychiatrists as their primary treating physicians on an ongoing basis.

During my residency training, from 1981 to 1985, I received no instruction whatsoever on childhood sexual abuse, its epidemiology, long-term consequences, treatment, or causes. I literally had no more expertise on childhood sexual abuse at the end of my training than a radiologist, except for reading I had done on my own outside my training. During this period, there was extensive discussion within Canadian psychiatry of the need to modify residency training programs in various ways, but no mention was made of childhood trauma in any of those discussions. From 1981 to 1985, I never heard a single psychiatrist or resident at my medical school express any concern about the lack of emphasis on childhood trauma within psychiatry. Nor did I hear serious childhood trauma mentioned in a single case presentation during those four years.

In journal club, I learned that many residents were unable to read the psychiatric literature from a critical, scientific viewpoint, and could not spot glaring, major methodological problems in published papers. This experience forced on me the realization that many psychiatrists are incapable of scientific analysis of a problem (Ross and Pam, 1995).

After my graduation, as I worked with more and more MPD cases, I learned that late twentieth-century psychiatry is actively opposed to accepting the reality of severe childhood trauma and its pervasive long-

term consequences throughout all of *DSM-IV*. This resistance takes many forms, including political backstabbing, passive–aggressive interference, overt anger, mockery, derision, and refusal of funding. Things have changed since 1985, but only very slowly, and MPD is still a topic for ridicule, jokes, and scorn in many psychiatric settings. The resistance is complex, active, and largely unconscious, and requires a great deal of energy: conscious, intellectual resistance is a small subcomponent of the overall process.

In the late twentieth century, academic psychiatry is actively refusing to deal with victims of serious childhood trauma, providing inadequate training in the area, and attacking those mental-health professionals who are doing their best to treat survivors. The mask of greater expertise, training, and critical thinking skills is false. Late twentieth-century psychiatry, as a profession, is undertrained to deal with the long-term consequences of serious childhood trauma. The average psychiatrist, by virtue of his or her academic training, is no more qualified to diagnose and treat sexual abuse survivors than a judge is qualified to hear child-custody cases by virtue of his or her legal training. In our society, a judge who has had no training of any kind in child development, family systems theory, or the social sciences, and has never practised family law can still decide a child-custody case. The training of most psychiatrists to deal with sexual abuse is equally deficient.

In 1991, before I left Winnipeg, I had a research assistant sit with thirty-one residents in the program individually while they completed a questionnaire on dissociation and sexual abuse. Out of the thirty-one residents, none could give sufficient criteria for somatization disorder to make the diagnosis, only eleven could list the two *DSM-III-R* criteria for MPD, four could list none of the eight criteria for borderline personality disorder, and thirteen could not list sufficient criteria to make the diagnosis of borderline personality, though many would dismiss patients with MPD as 'really just borderlines.'

When asked to list symptoms of unresolved childhood sexual abuse, twelve could list only three or fewer. When asked to complete the statement 'Current literature on borderline personality disorder estimates that ——% have been sexually abused prior to age 18,' the responses varied from 10 to 98 per cent, with five residents answering 25 per cent or less, and seven answering 85 per cent or more. The residents' estimates for the percentage of MPD patients who have been sexually abused varied from 30 to 100 per cent, though I had published original data, and a table summarizing all large studies on this question, in the

American Journal of Psychiatry the previous year. The range for reported rates of childhood sexual abuse in five large series of MPD cases is 63 to 90 per cent.

Asked what percentage of general adult psychiatric in-patients have been sexually abused, responses varied from zero to 80 per cent, with eight residents saying 1 per cent or fewer, and five saying 25 per cent or more. The literature indicates that the correct figure is probably about 50 per cent. For the percentage of females in the general population who have been sexually abused prior to age eighteen, responses varied from 1.5 per cent to 50 per cent, with five residents saying 10 per cent or fewer, and six saying 40 or 50 per cent. Concerning males in the general population, estimates ranged from 0.1 per cent to 60 per cent, with eight residents saying 5 per cent or fewer, and seven saying 20 per cent or more. Bagley and King (1990), summarizing all studies to that date, concluded that 5 per cent of boys and 15 per cent of girls are sexually abused in North America.

When I asked what percentage of general adult psychiatric in-patients have MPD, estimates ranged from zero to 80 per cent, with six residents saying 0.1 per cent or fewer, and five saying 25 per cent or more: (25 per cent is far above the figure obtained in a study I did in that department, and presented at Department of Psychiatry Grand Rounds, in which 5 per cent of general adult psychiatric inpatients were found to have undiagnosed MPD [Ross et al., 1992]). When asked what percentage of the general population has MPD, estimates ranged from 0.01 to 10 per cent, with five residents saying 0.1 per cent or less, and nine saying 5 per cent or more. I had published findings of a general population survey done in Winnipeg in 1991, in which 1 per cent of respondents met *DSM-III-R* criteria for MPD and reported a childhood trauma history (Ross, 1991).

Even more remarkable than these group findings were the patterns of responses by individual residents. One resident might say that 10 per cent of people in the general population, and 10 per cent of general adult psychiatric in-patients, have been sexually abused prior to age 18, indicating that childhood sexual abuse is not a risk factor for psychiatric hospitalization. Another resident would say that the rate of childhood sexual abuse is ten times higher among in-patients than in the general population, and another that it was ten times lower, indicating that the residents had no consistent understanding of whether childhood sexual abuse is a risk factor, a protective factor, or neutral, with respect to psychiatric hospitalization.

Asked to define psychiatric terms such as 'abreaction' and 'negative

therapeutic reaction,' many residents demonstrated that they couldn't define either one, and some gave a definition for 'negative therapeutic reaction' that actually defined 'abreaction,' and vice versa. It is important to recall that this is a department in which I was holding grants, giving Grand Rounds, teaching residents and medical students, and publishing a book and numerous papers on MPD, from 1985 to 1991. One would therefore assume that this group of residents is likely to be better informed on these topics than the average for all medical schools in North America.

The data and the sociological reality of late twentieth-century psychiatry lead to the inescapable conclusion that psychiatrists, by virtue of their training, are not qualified to assess the reality of Satanic ritual abuse. Not only are they inadequately trained concerning sexual abuse in general, they receive no training about destructive cults and learn nothing about the history of religion or Satanism during their residency programs.

The idea that most non-medical therapists treating Satanic ritual abuse survivors are inadequately trained and incapable of critical scientific thinking compared with psychiatrists is false. The unscientific viewpoint of non-medical therapists cannot be used as an explanation for why they see ritual abuse cases while scientific-minded psychiatrists do not. Lack of scientific training is not a differential factor, and the hypothesis that lack of such training fosters hysterical confabulations in patients is disproved, because the psychiatrists who do not see such cases are inadequately trained to think critically about the issue, and are not more scientifically minded than the therapists. To say that psychiatrists do not create confabulated ritual abuse histories in their patients because of their better scientific training is like saying they do not do so because they are taller: in fact, there is no height difference between psychiatrists and non-medical therapists, in this analogy.

The False Memory Syndrome Foundation

According to an annoucement by Pamela Freyd, PhD, Executive Director of the False Memory Syndrome Foundation, dated 4 May, 1992, the foundation was formed to

> address the problem that increasingly throughout the country, grown children undergoing 'therapeutic' programs have come to believe that they suffer from 'repressed memories' of incest and sexual abuse. While some reports of incest

and sexual abuse are surely true, these 'decade-delayed memories' are too often the result of False Memory Syndrome. False Memory Syrnrome has a devastating effect on the victim and typically produces a continuing dependency on the very program that creates the memory. False Memory Syndrome proceeds to destroy the psychological well-being of not only the primary victim but – through false accusations of incest and sexual abuse – of other members of the primary victim's family.

After a long period of silence, Jennifer Freyd, PhD, a professor of psychology at the University of Oregon, the daughter of Pamela Freyd, stated in public for the first time that she had been sexually abused by her father, Peter Freyd, in childhood (Mitchell, 1993). She described her childhood in detail during a presentation at the Center for Mental Health at Foote Hospital's Continuing Education Conference: Controversies Around Recovered Memories of Incest and Ritualistic Abuse, held in Ann Arbor, Michigan, on 7 August 1993 (Freyd, 1993).

Jennifer Freyd alleged that the sexual abuse by her alcoholic father began with fondling at age three, and escalated to intercourse at age sixteen. She also described a range of other sexualized behaviours by her father, including giving her a replica of his genitals as a gift, throwing a condom at her and her first husband, and, at a family Christmas dinner during Jennifer's adulthood, talking about how lesbians artificially inseminate themselves. Jennifer's parents allege that she is suffering from False Memory Syndrome (Mitchell, 1993). The historical roots of the False Memory Syndrome Foundation are in the Freyd family and its unresolved problem.

I admire Pamela Freyd for taking a family problem and transforming it into a major social issue and the topic of a conference co-sponsored by the False Memory Syndrome Foundation and Johns Hopkins University, held in Baltimore on 9–11 December 1994, which I attended along with about six hundred other registrants. I have spoken on the phone and corresponded with Jennifer Freyd, who is intelligent and articulate, and I have also spoken and corresponded with her parents. The origins of the False Memory Syndrome Foundation in the Freyd family, although important to recognize, should not necessarily determine the course or focus of public debate about memory, confabulation, and the effects of psychotherapy. Although the historical truth is of crucial importance for the Freyd family, it is not, as I have argued throughout this book, the key concern in therapy.

It is important to understand that, technically, there is no such thing as

False Memory Syndrome. No criteria for the syndrome have been published in a peer-reviewed journal, there are no studies of a scientific nature concerning it, and no one has ever demonstrated its validity or reliability. Even members of the foundation board have never defined the syndrome, except to say that it consists of false memories they blame on therapists, and the trouble that results. This absence of scientific status is the shortcoming foundation members say applies to MPD, a charge they make while ignoring a substantial scientific literature on the validity and reliability of MPD. There is not a single scientific study showing that a False Memory Syndrome created in therapy exists.

Things being so, I had assumed incorrectly that the motivation of the key foundation members was primarily to protect offenders and discredit survivors. This is the inverse charge of that made by foundation board member George Ganaway in an article in the special Fall 1992 issue of the *Journal of Psychology and Theology* devoted to Satanic ritual abuse. In his article, Ganaway says that 'suspension of critical judgement on the part of therapists treating alleged childhood trauma victims may be one of the strongest contributing factors to the growing "cottage industry" in the treatment of reported ritual abuse survivors.'

Given my initial assumptions, I was surprised to read an article by Ralph Underwager and Hollida Wakefield (1992) in the same issue of the *Journal of Psychology and Theology* entitled, 'The Christian and Satanism,' in a section entitled 'Christian Perspectives on SRA Phenomena.' The abstract of this paper (p. 281) reads as follows:

> Based on theological and psychological analysis of current claims and descriptions, the authors oppose the notion of a world-wide satanic conspiracy that brutalizes children. It is their conviction that there are no historical, theological, or psychological grounds for believing in the existence of such a conspiracy. Rather, scriptural and theological data affirm that Satan, the Prince of Darkness, is a wholly vanquished foe whose sole remaining capacity is telling lies. The penal freedom from the Law achieved in the Gospel permits the believer to accept the claims of God and to refuse to believe the lie of Satan.

To ensure that their point is clear, Underwager and Wakefield go on to enumerate the ways in which believers in Satanic ritual abuse are committing spiritual sins, and later (p. 285), they coin an additional syndrome, the 'Comstock syndrome', to describe belief in the worldwide conspiracy. Christine Comstock, a Fellow of the International Society for the Study of Dissociation, is a contributor to the special issue of the *Jour-*

nal of Psychology and Theology. The specific sins which believers in Satanic ritual abuse are characterized as committing include sloth, the ancient heresy of Gnosticism, folly, and lying, and the specific temptations to which they have fallen prey are listed as power, human needs, and the call for the proof of love. Although details are not given, one assumes that the additional spiritual sins of pride, envy, and despair listed by the authors are also committed by believers.

In an interview in the Winter 1993 issue of *Paidika: The Journal of Pedophilia*, Ralph Underwager and Hollida Wakefield discuss their views on paedophilia with journal editor-in-chief, Joseph Geraci (1993). In the interview (p. 12), Underwager has this to say:

> Take the risk, the consequences of the risk, and make the claim: this is something good. Paedophiles need to become more positive and make the claim that paedophilia is an acceptable expression of God's will for love and unity among human beings. This is the only way the question is going to be answered, of whether or not it is possible. Does it happen? Can it be good? That's what we don't know yet, the ways in which paedophiles can conduct themselves in loving ways. That's what you need to talk about. You need to get involved in discourse, and to do so while acting. Matthew 11 talks about the wisdom of God, and the way in which God's wisdom, like ours, can only follow after.

Underwager's views represent a mixture of psychology, Christianity, and apparent endorsement of paedophilia – definitely not the ideological framework of the False Memory Syndrome Foundation as a whole. Additionally, Underwager's writing is subject to scholarly criticisms of a type that cannot be made concerning the work of other advisory board members, many of whom have made serious scientific and scholarly contributions to their fields. Subsequent to the appearance of the *Paidika* interview, Underwager was asked to resign from the board, and he is no longer a member.

In a study supported by a 1988 grant from the New England Commissioners of Child Welfare Agencies, Anna C. Salter, PhD, analyses the scholarly and factual errors in Underwager's writing and testimony, based on a review of five hundred references. The report, entitled *Accuracy of Expert Testimony in Child Sexual Abuse Cases: A Case Study of Ralph Underwager and Hollida Wakefield*, cites Underwager's own statements that he has testified in more than two hundred cases of child sexual abuse in thirty-five U.S. states, Canada, Australia, and New Zealand, always on the side of the defence. (Salter's report can be ordered from

the American Prosecutors Research Institute, 99 Canal Center Plaza, Suite 510, Alexandria, Virginia, 22314; phone number 703-549-4253.)

With full references and citations, Salter (p. 4) enumerates the following difficulties with Wakefield and Underwager's work:

1 The research they cite sometimes simply does not say what they say it does.
2 They frequently cite research in a context where the unsuspecting reader would erroneously infer that the research relates to sexual abuse.
3 They frequently cite a minor finding of a study out of context in situations in which had they quoted it in context it would not have supported their position.
4 They will use a minor or outdated comment of an author as representing his/her position when they are aware it does not represent the author's position.
5 They state positions as facts when there is no research evidence to substantiate their claims.
6 They simply ignore contrary evidence.
7 They extrapolate beyond the limitations of the data.
8 They leave crucial information out of quotations.
9 They cite studies of adults in places where the unwary reader would assume they were referring to studies of children, without noting that they are of adults.
10 They make numerous logical errors.
11 The citations themselves are so filled with errors that it is difficult to find many of them.

The False Memory Syndrome is much discussed in the media (Wright, 1993a; 1993b; 1994), at professional meetings, and in legal cases. Like any organization or movement, the foundation has attracted members who do not always maintain scholarly standards. It is important that opponents of the foundation not focus exclusively on such individuals, or overgeneralize from them to all foundation members. This would be a self-defeating political strategy, an example of the psychology of Satan, and inaccurate. Refutation of Ralph Underwager does not represent a refutation of all viewpoints encompassed by the foundation.

At the meeting in Baltimore on 9–11 December 1994, speakers expressed adherence to divergent and even conflicting viewpoints, including: denunciation of the validity of the concept of repression; clas-

sical psychoanalytical theory; trauma dissociation theory as enunciated by Pierre Janet; cult-exit counselling; biomedical–genetic theories of mental illness; and family systems theory. The dominant orientation was psychoanalytical.

I learned several things at the meeting. There are many reasonable people in the False Memory Syndrome Foundation who are interested in establishing a meaningful interchange with those in the opposite camp; many foundation members are more concerned with standards of practice than memory issues as such, and within the foundation there are a number of different interest groups, and much potential for divisiveness.

Overall, the reception I received at the meeting was cordial, and many people expressed their gratitude for my attendance, including psychologists, psychiatrists, retractors who have successfully sued their therapists, lawyers, accused fathers, and wives of accused fathers. Many of the people I spoke with had preconceived opinions about me based on *rumour*, and assumed that I practise a stereotyped 'recovered memory' therapy. A published example of such rumour is the statement by Mark Pendergrast (1995, p. 162) that, 'in the early 1980's, a core group of therapists – Bennett Braun, Richard Kluft, Eugene Bliss, George Greaves, David Caul, Colin Ross, and Frank Putnam – cranked out articles on MPD.'

I didn't complete medical school until 1981, and my first article on MPD was published by False Memory Syndrome Foundation advisory board member Martin Orne in his *International Journal of Clinical and Experimental Hypnosis* in 1984, my second in 1985, and my third in 1987. Much unnecessary distortion in each camp's perception of the other could be corrected by attendance at the same meetings. The split between the International Society for the Study of Dissociation, of which I was 1994 president, and the False Memory Syndrome Foundation is yet one more manifestation of the psychology of Satan.

Members of both camps project badness onto the opposition. The rumours I encountered about myself are reciprocal of therapist beliefs that False Memory Syndrome Foundation members are paedophiles and Satanists. Even the existence of two dissociated camps is a borderline split within the larger system of the mental-health field. The cognitive errors, misinformation, and urban legends of both camps require correction.

The social dynamics of the False Memory meeting in Baltimore in 1994 were the mirror-opposite of those at an MPD meeting in Chicago in 1988. Both meetings were a combination of academic conference and

social movement, with the focus of concern being on victims. At Chicago, the highest-ranking victim was a female with MPD, the absent perpetrator a Satanic high priest, and the rescuer a therapist. In Baltimore, the victim was a falsely accused father, the perpetrator an absent therapist, and the rescuer a lawyer. In both instances, the rescuer–victim–perpetrator triangle was being acted out as a social policy, the only difference being in the demographics of the individuals filling the roles.

At both meetings, most of the speakers were males with MDs and PhDs, while the audience was a heterogeneous mixture of victims, their significant others, paraprofessionals, and mental-health professionals. In Chicago, the audience was younger and predominantly female, and contained few mainstream psychiatrists; Baltimore's was older and predominantly male, and contained many more psychiatrists. At both meetings, victims in the audience could be seen getting back rubs from their companions, and both audiences gave standing ovations to orators espousing the group doctrine. There were survivor forums at both meetings, and, at Baltimore, undisguised retractor families were on stage for discussion of their case-histories. Many individuals in both camps would have viewed public display of the opposite camp's recovering victims as distasteful.

The two camps are mirror-opposites of each other, and each is the other's Satan. The treatment of this dissociation, if it is to be successful, will have to involve principles such as making friends with Satan, understanding that the presenting problem is not the problem, and increasing interpersonality communicaton and cooperation. The International Society for the Study of Dissociation and the False Memory Syndrome Foundation are mutually antagonistic alter personalities in a larger social system. Like alter personalities inside individual human beings, they need to talk.

Skepticism and Negative Hallucinations

Negative hallucinations are common and, in psychoanalyical theory, hysterical in nature. A negative hallucination occurs when someone doesn't see something that *is* there, and is the opposite of a positive hallucination, in which one sees something that *isn't* there. A good example of a negative hallucination is the medieval bishop who looks in the pants of a bewitched Christian and observes that his genitals are missing. The historical question is, 'Who was more hysterical, the Inquisitor or the Witch?'

Extreme skeptics about Satanic ritual abuse could be experiencing a negative hallucination; in the twentieth century, the most common error in the mental-health field concerning actual severe child abuse has been not to see, study, or acknowledge it.

The Psychology of Frivolous False-Memory Lawsuits

The most pressing issue for the dissociative-disorders field, in 1995, is false memories and the many frivolous lawsuits against therapists for implanting false memories that can be expected over the next couple of years. The field needs to counter flagrant acting-out against its membership. One way to do this is by understanding how frivolous false-memory lawsuits are a manifestation of the psychology of Satan. The following logic may be of assistance to therapists under legal attack for their work with Satanic ritual abuse cases.

Several things are clear. The first is that normal human memory is highly error-prone. This is true of all biological processes, from DNA transcription to immune responses: the built-in capacity for error is one of the foundations of biological survival, in that it allows for change, novel responses, and adaptation. There is no need for therapists to be defensive about the fact that Satanic ritual abuse clients have false memories, since everyone does. False memories are biologically normal, and therefore not necessarily the therapist's fault.

Second, in analogy to DNA processing, traumatic memory is guaranteed to include mutations, deletions, transpositions, and insertions, since this is true for all memory. It is natural and expectable that traumatic memory will include inaccuracies related to errors of registration, retention, and retrieval. This, again, is not the therapist's fault; it is not possible to go through therapy without retrieving false memories to some degree, since all memory contains a degree of falsehood. There are no scientific data on the rate of error in MPD patients' memories compared with rates in memories of other diagnostic groups and normal controls.

Third, it is a fact that suggestible individuals can have memories elaborated within their minds because of poor therapeutic technique. The mechanisms are similar to the techniques of persuasion used by politicians, advertising agencies, or anyone who wants to influence another person's perception of past, present, or future: in therapy the persuasion is an artefact of bad technique rather than the goal of the intervention. No one launches suits against advertisers for creating false needs, or pol-

iticians for creating false votes, though such suits are no less rational or plausible than a false-memory suit against a therapist.

Fourth, patients and clients must fundamentally be responsible for their own memories, just as they are responsible for their own feelings and behaviour. The therapist is a consultant to the recovery process, not the director of it. In part, I think, false-memory suits are driven by a reaction to overinvolvement and rescuing behaviour by therapists, who then get placed in the persecutor role by the client, as the dyad oscillates around the rescuer–victim–perpetrator triangle. Abstaining from participation in the rescuer role should reduce the likelihood of getting forced into the persecutor role.

Part of the motive for false-memory suits, I think, is patients and clients acting-out their rage about being held responsible for their thoughts, feelings, memories, and behaviours. One of the deepest needs created in a sexually abused child is to avoid responsibility for the incest – not to have wanted it, caused it, or liked it. At the same time, the child shifts the locus of control for the abuse inside herself, in order to create an illusion of being in control of the uncontrollable: this developmentally protective illusion preserves a sense of power and mastery and an orderly, predictable universe. The cost of the strategy is to be bad, to have caused the abuse, and to deserve further abuse, from alter personalities or other people. In terms of the psychology of Satan, the cost of the locus of control shift is to have Satan inside oneself. The badness must be projected back out into the outside world, or onto other alters, thereby locking the person into a cycle of introjection and projection. First, the perpetrator is evil, through the abuse; then, the self, through a locus of control shift; then, the perpetrator, in therapy; then, the therapist, during the false-memory lawsuit; then, if the false-memory suit fails, the self again, the lawyer, or the father.

The dissociative-disorders field has effectively blocked the claim that people with MPD are not responsible for the actions of their alter personalities. This is good, and a foundation of recovery. Psychodynamically, however, in the deep psyche, responsibility for one's alters implies that the child was responsible for the abuse. This conclusion is experienced by the unconscious as blame by the therapist, who then becomes a perpetrator, and the target of angry acting-out. The unconscious counterlogic is to claim that the memories were implanted by the therapist and never happened. Since the client must accept responsibility for the actions of her alters, she evades responsibility for the abuse, in magical logic, by not being responsible for her memories, and by claiming that

the abuse never happened. There is a classical Freudian pun in the charge that false memories are *implanted* by therapists – the therapist has been identified with the incest perpetrator, who implanted semen in his daughter. The false memories are like an incest pregnancy, blame for which the victim must disavow. A false-memory suit is an unconscious acting-out of this conflict. The conflict is an inevitable, normal, and treatable consequence of childhood sexual abuse; a problem arises when the conflict is acted-out in the courts, rather than healed.

Fifth, false-memory suits are reinforced by massive secondary gain, far exceeding any that could ever be derived from therapy. Major financial awards and pseudo-reconciliation with the family of origin, with sealing-over of family lies, secrets, and conflicts, are rewards with which a therapist cannot compete. A false-memory defence is the best legal strategy for a perpetrator in the present legal and political climate.

Sixth, there are undoubtedly falsely accused perpetrators, but such false memories are not necessarily the therapist's fault. The client has flipped the rescuer–perpetrator roles to pursue secondary gain. Logically, the therapist should be able to sue the parents for false memories of therapy, as much as the parents should be able to sue the therapist, since both parties are pawns of projective identification. During therapy, the client creates false memories of abuse to place her father in the perpetrator role and her therapist in the rescuer role, and to receive secondary gain from the therapist. When the external contingencies shift, the father is switched to the rescuer role (this may be the actual father, and/or a father–lawyer), and the therapist becomes the perpetrator, in order to receive the inverse secondary gain. The question is: who is Satan, and who is God – therapist, self, or father?

Seventh, clients with false memories should be treated countertransferentially, more like the medical profession regards patients with Münchausen's Syndrome (Feldman and Ford, 1994). We are experiencing an epidemic of a dissociative variant of Münchausen's. The attitude towards doctors who are fooled by medical Münchausen's cases is very different from that towards the therapist in a false-memory suit. The doctor is viewed as a conscientous, ethical, competent professional, one in a long series of professionals duped by a con artist. There is no epidemic of false-illness suits launched against doctors by medical–surgical Münchausen's patients.

Eighth, it is very difficult to tell a false from a real memory clinically. There are undoubtedly incompetent therapists who should be successfully sued, just as there are incompetent individuals in every profession.

However, I am confident that the bulk of current false-memory suits are an acting-out of the psychology of Satan, reinforced by secondary gain. What I have learned from the false-memory controversy is that false memories are a profound, subtle, and difficult problem in both therapy and research.

False memories will be a significant source of revenue for lawyers over the next few years. Expert witnesses on false memory appearing for accused perpetrators must have made millions of dollars in fees, given the number of cases in which they have testified. Juries need to be instructed in the difficulty of differentiating true from false memories, and the subtle puzzle of whether the false-memory suit is based on a true or false account of therapy, plus the reinforcement of false memories of therapy by families, lawyers, and courts. The persecution of therapists through unfounded false-memory lawsuits in the 1990s is a psychological variant of the Catholic Inquisition. This is so despite the fact that some false-memory cases are undoubtedly legitimate and proper.

Conclusions

In this chapter, I have examined the polarity of the public debate about Satanic ritual abuse and focused on the shortcomings of the extreme skeptical position, having criticized therapists more extensively in the preceding two chapters. The polarity is an acting-out of the cultural themes of dissociation and projection, hysteria and denial, God and Satan, as are frivolous false-memory lawsuits.

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Future Directions

Given the polarized state of current discussion about Satanic ritual abuse, the most likely development is that unproductive polarization will continue for at least a few more years, then be followed by a gradual rapprochement, with representatives of both extremes being publicly discredited and successfully sued before that can happen.

The balance of social forces could tip in any one of several directions, depending on the economy, whether conclusive evidence of Satanic ritual murder is uncovered, the outcome of key court cases, and the degree of interest the media continues to take in Satanism. It is possible that public interest in Satanism could fade out over the remainder of the decade, with Hollywood and heavy-metal rock music exploiting different imagery and fundamentalists finding a different manifestation of Satan to combat. Alternatively, a right-wing witch hunt could begin, with believer therapists the primary target; this seems more likely than the families of survivors being persecuted. Another possibility is that Pat Robertson's viewpoint will prevail, with the witch hunt targeted at female survivors, socialists, feminists, and pro-choice advocates. The question is: who will get to be God, and who Satan, victim, and perpetrator?

In 1993, media pressure shifted to attacking therapists, blaming them for survivors' confabulated memories and increasing the likelihood of large settlements against them in court. I see this as the most likely direction of change over the rest of the decade. The backlash will affect public attitudes towards child abuse in general, and will be used by academic psychiatry as a rationalization for hostile political statements about non-medical therapists and their inferior training. Some Christian fundamentalists will state that the therapists were clearly influenced by

the Father of Lies, while others, undaunted, will continue to believe in the reality of Satanic ritual abuse and cite it as evidence of Satan's activity in the world: for them, these will be late times.

Given the possibilities described above, I will now briefly outline the directions and developments I would like to see over the next ten years.

Future Empirical Studies on Satanic Ritual Abuse

Several lines of study are required at this point within the mental-health field and social sciences. One is scholarly and archival, and would result in a definitive study of human sacrifice, cannibalism, destructive cults, Satanism, occult sexual practices, and related matters. A study of contemporary destructive cults directly comparing them to the alleged Satanic cults in a detailed structural analysis should also be done. Our base of scholarly information about Satanism is deficient.

Another line of research would involve questionnaire surveys of various professional groups such as child-care workers, clergy, school guidance counsellors, and others on the periphery who have less direct contact with survivors. We lack any consistent database for the number of people with Satanic ritual abuse memories, the number of professionals in contact with them, the levels of Satanism reported, consistency of reports geographically and by person receiving the reports, and so on. It would be interesting to know whether the accounts of survivors differ significantly according to the training and attitudes of the person they are talking to, and this should be studied without ideological bias.

At present, variability in the content and frequency of reports is usually cited as evidence that believer enthusiasm is stimulating confabulation, but this is a conclusion driven by ideology, not science. Parallel logic would be to conclude that an epidemiological skew in the demographics and training of citizens detecting acute intermittent porphyria is evidence that it is not real. A better explanation is that only physicians will make such diagnoses; within physicians, primarily internists; and, within internists, primarily a small subspecialty group.

A primary requirement is for studies to be more disinterested in the future. Although skeptics might object that such studies stimulate confabulation, we require a more detailed profile of the alleged activities of Satanic cults and the symptoms of survivors. My preliminary research mentioned in earlier chapters suggests that, on a dissociative-disorders unit, Satanic ritual abuse cases may not differ in terms of symptom profile from non-ritual cases. If this is a true finding, it is counterintuitive

from a believer point of view, and could be used to argue that the lack of increased symptom severity in Satanic cases implies that the survivors never actually experienced the ultra-severe trauma they are remembering. Alternatively, there may be a ceiling effect, in which patients selected into such units are all near the maximum possible symptom level, so current measures cannot differentiate subgroups within the population: the Satanic cases may have experienced less subjective trauma than expected because of the greater structure of their abuse; or the Satanic ritual abuse survivors may have dissociated their more severe trauma more effectively, resulting in their symptom severity equalling that of less traumatized, non-ritual MPD cases. Differentiating between these hypotheses would be difficult.

Treatment outcome data are sorely needed. At present there is no information to support the claims of believers or skeptics about what constitutes the best treatment. It is possible that stimulating confabulated memories could improve outcome, for all we know, because false memories could give the survivor a culturally sanctioned myth which reduces self-blame and provide a social context for trauma which otherwise seems arbitrary and chaotic. This is also true for non-ritual MPD. One would then have to do a cost–benefit analysis of the positive individual treatment-outcome effects of confabulation versus negative social consequences.

Similarly, the negative consequences to families of false allegations are often taken as a given, but, if worked through in good family therapy, they might conceivably be understood as an opening move in an eventual reconciliation and healing. In this scenario, the negative consequences of an adversarial legal reaction to false allegations versus a conciliatory supportive stance would have to be studied. If the allegations are false, the cause of long-term family estrangement might be the reaction to them rather than to the initial allegation. Although healthy, innocent family members would naturally be hurt by such allegations, why would they respond with adversarial hostility towards the survivor rather than support? These permutations of the systems-dynamic possibilities could be investigated in longitudinal case-studies.

Studies comparing Satanic ritual abuse survivors with individuals who were born into documented deviant cults and violent subcultures around the world should be undertaken. At present there is not a single published clinical research study of Satanic ritual abuse involving a comparison group and statistical analysis. The point I am making is that

Satanic ritual abuse is a topic that could be studied, just like any other subject area.

The memories of MPD patients alleging childhood participation in Satanic cults should be studied experimentally. By this I mean that experimenters should study these patients within established memory paradigms such as those for eyewitness memory developed by Elizabeth Loftus (Loftus, 1993; Loftus and Ketcham, 1994). MPD patients are rich subjects for cognitive-developmental, neuropsychological, and memory research of all kinds, and have infinitely more interesting memories than do university undergraduates. Academically, the capacity of MPD patients for amnesia, hyperamnesia, and confabulation should all be viewed as interesting and worthy of serious study.

Law-Enforcement Initiatives

We require a thorough, scholarly analysis of the current law-enforcement data on all levels of Satanism, and a detailed review of all the cases cited in Linda O. Blood's *Satanism and Satanism-Related Crime: A Resource Guide* (available from American Family Foundation, P.O. Box 336, Weston, Massachusetts, 02193) and in her *The New Satanists* (1994). There are dozens of cases with many convictions cited in the bibliography, but one cannot tell the level of Satanism, or the nature of the evidence, from the citations. It appears that there may be a substantial case law on crimes with Satanic elements.

Law-enforcement issues are reviewed in a training manual entitled *Adolescent Chemical Dependency and Satanic Cults* produced jointly by the Institute for Training Professionals and Management, Federal Bureau of Investigation, Buffalo Division, and Brylin Hospital and Chemical Dependency Treatment Center (available from Gary J. Metz, State University of New York College at Brockport, Brockport, New York, 14420). Another key resource is the *Research Update* 6/1 (Winter 1989–90), Office of Criminal Justice Planning, State of California (available from Office of Criminal Justice Planning, 1130 K Street, Suite 300, Sacramento, California, 95814).

I also recommend the *Report of the Virginia State Crime Commission Task Force Study of Ritual Crime*, House Document No. 31 (available from Commonwealth of Virginia State Crime Commission, General Assembly Building, 910 Capitol Street, Suite 915, Richmond, Virginia, 23219). Although brief, *A Law Enforcement Primer on Cults* by Dale W. Griffis, PhD, is also worth acquiring (available from ADWG Enterprise, Box 39,

Tiffin, Ohio, 44883). It includes the names and addresses of a number of agencies and resources that provide information and support concerning Satanism and destructive cults.

Kenneth Lanning's *Investigator's Guide to Allegations of Ritual Child Abuse* (available from Behavioral Science Unit, National Center for the Analysis of Violent Crime, Federal Bureau of Investigation, FBI Academy, Quantico, Virginia, 22135) provides a thorough, detailed, and balanced analysis of the issues.

These materials together provide the initial information required for a scholarly review of legal cases, and case law on Satanism. I have no expertise in law enforcement, but I agree with recommendations made by those who do have expertise. It appears that the investigation of ritual crime scenes is often done by officers without adequate training who miss significant clues: for instance, how many officers know that finding coins in multiples of seven is evidence of Brujerian voodoo?

There appear to be several interrelated problems within law enforcement and the criminal-justice system: ritual crime is not categorized separately, or systematically entered into a national database; ritual evidence is often suppressed, or not introduced in order to prevent it from 'contaminating' the case in court; investigations are prematurely stopped when ritual elements emerge; investigations are said to have been thorough, and to have yielded negative findings, when they were never completed; jurisdictional disputes between agencies block adequate investigation; training of investigators is deficient; the subject of Satanic crime is suppressed because it is too politically controversial; an active interest in ritual crime is often left by default to Christian-fundamentalist officers, who have a doctrinally driven interest in it rather than a strict law-enforcement interest; ritual crime is given low funding priority; there is insufficient personnel across the board in law enforcement; and law-enforcement leadership declines to examine the issue systematically.

It appears that one or more convictions for Satanic ritual murder based on solid physical evidence and investigation are required before a significant shift will occur within the law-enforcement area. The siege of the Branch Davidians in Waco, Texas, will, one hopes, help to convince those in charge of law-enforcement agencies that destructive cults require expert study and investigation. The future direction in law enforcement should involve the careful application of mainstream methods of study and investigation to the problem of Satanic crime. For this to occur, it is important for law enforcement not to get bogged down in

debates about whether Satanic crime is 'really' Satanic or motivated by the usual drivers of criminal activity. A conclusion about this question can be made tentatively only after much more study.

Satanism in the Media

Certain sectors of the media will continue their sensationalist exploitation of Satanism for ratings, circulation, and income, but the responsible media should consider taking steps to counter the polarization of discussion about Satanism. Whenever a program or article is being done on Satanic ritual abuse, experts should not merely be asked for a statement but should be asked how they know that what they are saying is true. Experts should be carefully questioned on the number of survivors they have interviewed personally, their direct knowledge of the practices of therapists, and the sources of their information. They should also be asked about their motivation for speaking publicly on the issue and their reasons for being interested in Satanism. The purpose of such questioning would be to establish the ideological biases driving the experts' opinions.

Current media treatments tend to emphasize the polarization of opinion rather than any common ground. The focus should be on establishing what we do know for a fact, rather than on what experts insist *should be* the facts. The best contribution of the media would be high-quality investigative journalism, such as the Watergate investigation done by *The Washington Post*. Woodward and Bernstein persevered against extensive deception and cover-up, and brought to light facts many Americans would have considered impossible, resulting in the impeachment of a president. The investigation of Satanic ritual abuse poses similar challenges.

The Dissociative-Disorders Field

The dissociative-disorders field does not have its house in order concerning Satanic ritual abuse. The dissociative-disorders field should work to repair the unproductive polarization which has overcome it, which would best be done at meetings and in professional journals, not on television, and this should be a high priority within the field. Satanic ritual abuse hysteria has become linked to MPD, and the diagnosis is being rejected as on a par with alien abduction, past-life regression, and Satanic cannibalism. Although this is an illogical and unscientific attack on MPD, it is in part fuelled by the excesses of believer therapists.

Having undergone a paradigm shift into a trauma-dissociation model

of psychopathology, therapists now need to undergo a sub–paradigm shift concerning the imprecision of both normal and traumatic memory. All memory is a reconstruction, and all perception involves multiple transductions of signals in the brain.

Conclusions

Satanic ritual abuse will continue to be a serious social problem throughout the 1990s, and into the twenty-first century. No matter how much Satanic crime is actually going on, and how organized it is, the topic of Satanism will continue to be devisive and destructive within our society. My position is that 10 per cent of the memories could be real: this is not an estimate, it is simply an illustrative figure for discussion purposes. Clear clinical examples of confabulated Satanic ritual abuse memories are not difficult to accumulate, any more than are any other kinds of false allegations in our society. At the same time, however, not all cases involve hysteria, secondary gain, alienation of families, or other negative consequences, and some alleged survivors in therapy are moving steadily towards integration and improved function.

My conclusion is that there is no conclusion concerning the sociological reality of multigenerational orthodox Satanic cults. The purpose of this book is not to answer that question. My goals will have been achieved if my thoughts help to counter the destructive polarization of the debate, illuminate the underlying cultural dynamics of the psychology of Satan, and establish the principles of sound psychotherapy.

For therapists, the important principle is to be aware of the central paradox of MPD, not to get drawn too far into the inner hypnotic reality of the disorder, and not to pull out too far into skepticism. Treatment of Satanic ritual abuse survivors must be grounded in general principles of therapy, and should not differ much from the treatment of non-ritual cases. In therapy, the same interventions can be used no matter what percentage of the memories are historically accurate. Further, the memories are not the primary target of the therapy: therapy has its healing effect in the present, at the level of process and structure; the informational content of the memories is a minor consideration compared with the internal conflicts, cognitive errors, unresolved traumatic feelings, lack of fluid and adaptive coping skills, and wide range of disabling symptoms.

Satanic ritual abuse survivors, properly understood, have a great deal to teach us about the nature of memory. They embody, in crystallized, observable behaviour, our deepest cultural fears and sickness. Therapists should listen to them carefully, while not believing too much.

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Afterword

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Colin Ross begins this book with a series of quotes; two are from Freud, another from a Dallas newspaper, but the one I found most apt was from Brunvand's *The Vanishing Hitchhiker*. And the particular portion of this quote that is especially apt is that about the importance of stories in the lives of people: ... the stories that people believe to be true hold an important place in their worldview. "If it's true, it's important" is an axiom to be trusted, whether or not the lore really *is* true or not.' While experts in English language usage might rightfully wince at the number of 'or nots' in this statement, its message is none the less essential. For it is in this sense – the 'life stories' sense – that Satanic ritual abuse is important. This is the story that some people believe to be true about themselves and, in that sense, it is important whether the lore '*is* true or not.'

Of course, deciding whether the lore of Satanic ritual abuse is true or not is hampered by a problem repeatedly emphasized by psychiatric anthropologist Sherrill Mulhern – namely, that there is little consensus as to what the term 'Satanic ritual abuse' even means. Although clear definitions may be hard to come by, for some patients the concept seems to mean a chronic history of 'ritual torture, incestuous rape, sexual debauchery, sacrificial murder, infanticide, and cannibalism perpetrated by members of clandestine Satanic cults' (Mulhern, 1994, p. 265). Whether one believes in the reality of most, some, or no stories of ritual abuse of this type, we should all be interested in understanding what might lead someone to hold this out as his or her personal story. Moreover, whether one believes that the cases of MPD are never, sometimes, or always iatrogenically created, we should all be interested in understanding what might lead someone to exhibit alter personalities as part of his or her personal story.

When Dr Ross initially invited me to write an afterword for his new book on Satanic ritual abuse, I thought I had misheard him. Having been embroiled in the battle over repressed memories for some years, I know only too well how polarized the intellectual battleground had become. I'd seen so many instances of people who disagreed acting in contemptuous and arrogant ways, attacking the character of people, rather than engaging them in scholarly dialogue. After two decades in the academic world, I wasn't accustomed to such cheap, deplorable tactics. I've learned a modicum of suspicion. So, my first thought: Was this a trick? My second thought: Was he reaching our for a genuine dialogue? In any event, one thing was clear: *I* wanted to read the book. What I found sometimes surprised me, sometimes pleased me, sometimes angered me. I suspect many readers will have had similar reactions.

Early in the book, Ross makes clear his interest in reducing the unproductive polarization that now exists between the firm believers in the reality of Satanic ritual abuse memories and the skeptics who believe that these memories are not real. I applaud his goal of reducing polarization. But how to accomplish this? Many skeptics undoubtedly wish that Ross would stand up and say 'I was wrong. It doesn't exist. All these Satanic memories we've seen are false.' Some skeptics would argue that Ross should abandon his treatment methods, just as medical doctors abandoned their early treatment of pneumonia with the popular, although useless, castor oil, chloroform, ammonia, brandy, or opium. Those skeptics will be disappointed, as Ross doesn't go that far. However, he has taken some major steps. For example, he does acknowledge having seen cases in which a collateral history has proven that the patient's memories of Satanic ritual abuse were false. Moreover, for the sake of discussion, Ross does go so far as to suggest that perhaps only 10 per cent of the content of the memories might be historically accurate. This surprised me.

What does it mean to suggest that 10 per cent of the content of Satanic ritual abuse (SRA) memories might be accurate? Does it mean that 10 per cent of the cases of SRA are wholly true? Ross spends considerable time trying to convince his readers of the likelihood of SRA though his discussions of real-life Evil. Most of us would agree that, throughout history, people have done horrible things to one another, and, sadly, they continue to do so today. But just because the Catholic Inquisition took place, and Nazi Germany existed, and cults have engaged in mass suicide, and cases of horribly violent sexual abuse have been documented is not proof that there are vast number of intergenerational Satanic cults

engaging in ritual abuse, animal sacrifice, baby breeding, baby sacrifice – all the usual suspect elements. The failure of law enforcement to document even one of these is an important piece of the puzzle, despite Ross's protestations to the contrary.

Perhaps when Ross talks about 10 per cent of the memories being true, he means that 10 per cent of the elements of memories might be true in the sense that they reflect real experiences. Of course, my reaction to this interpretation is that some percentage of most false memories contain 'accurate' elements. For example, I and my colleagues created false memories in people that as children they were lost for an extended period of time in a shopping mall, that they were crying and scared, and that they were ultimately rescued by an elderly person (Loftus and Ketcham, 1994). The false memories that developed did include real locales in which the family used to shop. They included real family members who would have gone on family shopping trips. They included real 'memories' about being scared. These elements were simply combined in novel ways, and elaborated upon in a complex subject-and-experimenter interaction. And, *voilà*, a false memory was created containing a percentage of 'accurate' elements. The accurate elements, in fact, provide the seeds from which the rest of the confabulated memory flourishes. So it is not hard to believe that a false memory of Satanic ritual abuse might contain some historically accurate elements (e.g., a barn or a cemetery with which the patient was familiar as a child, a grandfather or uncles whom the patient knew well).

How do people come to develop Satanic ritual abuse memories? I and others have worried that the process of constructing these memories begins when a patient wanders into therapy and is told point-blank: 'I think you may have been sexually abused as a child.' Perhaps more insidious is the technique used by some professionals of repeatedly and subtly hinting at the possibility of child sexual abuse over a period of weeks or months, until the client comes to think that she has arrived at the hypothesis herself. And then begins the excavation of the 'repressed' memories through invasive therapeutic techniques such as age regression, guided visualization, trance writing, dream work, body work, hypnosis, and drug therapy. On occasion the resulting 'memories' evolve into quite elaborate creatures, as occurred, for example, in one case described in detail by Martha Rogers (1992), one of the experts who testified in the resulting court case.

A woman in her mid-seventies, Ellen, and her recently deceased husband were accused by their two adult daughters of rape, sodomy, forced

oral sex, torture by electric shock, and the ritualistic murder of babies. The older daughter, forty-eight years old at the time of the lawsuit, testified that she was abused from infancy until age twenty-five. The younger daughter alleged abuse from infancy to age fifteen. A granddaughter also claimed that she was abused by her grandmother from infancy to age eight. The memories were recovered when the adult daughters went into therapy in 1987 and 1988. After the break-up of her third marriage, the older daughter started psychotherapy, eventually diagnosing herself as a victim of multiple personality disorder and Satanic ritual abuse. She convinced her sister and her niece to begin therapy, and joined in their therapy sessions for the first year. The two sisters also attended group therapy with other multiple personality disorder patients who claimed to be victims of Satanic ritual abuse.

In therapy the older sister recalled a horrifying incident that occurred when she was four or five years old. Her grandmother caught a rabbit, chopped off one of its ears, smeared the blood over her body, and then handed the knife to her grandchild, expecting her to kill the animal. When the child refused, her mother poured scalding water over her arms. When she was thirteen and her sister was still in diapers, a group of Satanic cult members demanded that the sisters disembowel a dog with a knife. She remembered being forced to watch as a man who threatened to divulge the secrets of the cult was burned with a torch. Other members of the cult were subjected to electric shocks in rituals that took place in a cave. The cult even made her murder her own newborn baby. When asked for more details about these horrific events, she testified in court that her memory was impaired because she was frequently drugged by the cult members.

The younger sister remembered being molested on a piano bench by her father while his friends watched. She recalled being impregnated by the cult at ages fourteen and sixteen and having both pregnancies ritually aborted. She remembered one incident in the library where she had to eat a jar of pus and another jar of scabs. Her daughter remembered seeing her grandmother dressed in a black robe carrying a candle, and also remembered being drugged on two occasions and forced to ride in a limousine with several prostitutes.

Are the women's memories authentic? The 'infancy' memories are almost certainly false memories, given the scientific literature on childhood amnesia. Moreover, no data in the form of bones or dead bodies or missing-person reports were ever produced that might have corroborated the human-sacrifice memories. If these memories are indeed false,

as at least some of them clearly are, where would they come from? Psychiatrist George Ganaway was one of the first to publicly suggest that unwitting suggestions from therapy play an important role in the development of false Satanic memories. Despite the fact that Ross acknowledges that 'suggestible individuals can have memories elaborated within their minds because of poor therapeutic technique,' I feel that the devastation that some therapists cause when they unwittingly create false memories is not fully appreciated.

Consider what happened to a woman I will identify as Susan. According to court documents, Susan sought treatment for depression, anxiety, and panic attacks. However, some of her treating psychotherapists instead decided that what she needed was to 'recover' her 'repressed memories' of abuse. Using hypnotic and other suggestive and coercive techniques, they led Susan to believe that she had been sexually abused by her mother, father, and other family members, and that her family was part of an extended, transgenerational Satanic cult that engaged in the torture, murder, and cannibalism of numerous adults and children. Susan became convinced that her mother had been the high priestess in a Satanic cult, and that she, Susan, was being groomed for that position. Susan came to believe that she had more than a thousand alter personalities and, through one of these alters, had abused her own son. When Susan resisted the trauma search therapy and had trouble recalling Satanic experiences, she was told that her doubts meant that she was in denial; that her denial was the result of the cult's 'programming'; and that, if she continued to resist treatment, her health would not improve. After years spent acquiring these beliefs and memories, Susan eventually came to realize that her new 'identity' was a false one. She filed suit against her former therapists, alleging negligence, fraud, and conspiracy. This case of failed therapy produced countless problems for Susan, her children, her extended family, and now for the therapists who once believed that they were helping her. To have any kind of meaningful dialogue about patients, therapy, memory, trauma, and related issues, both Colin Ross and I must agree that coercive techniques that create false memories and beliefs must be stopped – and I think we do agree on this important point.

But how should patients be treated who, upon entering therapy, are already expressing Satanic ritual abuse memories and/or symptoms of multiple personality disorder? Say, for example, a patient comes in with memories and symptoms that emerged in prior therapy. What is the new therapist to do? At the outset, it must be made perfectly clear that skep-

tics may reject the beliefs and practices of some SRA/MPD specialists, but they do not and must not reject the patients. To mock them or abandon them might be considered unprofessional, and even cruel. Colin Ross believes that 'ideological neutrality' is the stance a therapist should take. Sounds good. At times, Ross seems to be taking his own advice, as when he discusses the use of sodium amytal to reveal hidden memories and acknowledges that there may be 'no truth in truth serum,' and when he makes clear the distinction between the therapy setting, where 'believing the client' might be a good guiding principle, and the legal setting, where 'innocent until proven guilty' guides. One hopes that readers of the book will take to heart Ross's point about the destruction that befalls both the therapist and the client when they foster groundless suits and alienation of relatives.

Elsewhere in the book, I wonder about Ross's neutrality. Is it ideologically neutral to treat alter personalities *'as if* they are separate people,' as Ross advocates? Psychiatrist Paul McHugh (1993, 1995) and others would say 'no'; in fact, they explicitly recommend ignoring the alters ('One simply never talks to an alter': McHugh, 1995, p. 114). From the point of view of psychological learning theory, well grounded in empirical research, that approach makes more theoretical sense to me. When you want a particular behaviour to stop, you stop reinforcing it. Would ignoring the alters better help patients achieve mental health? It is an empirical question. If Ross thinks it is more effective to forge a 'solid treatment alliance' with the alters, have there been research programs to assess these therapeutic claims? In my examination of scores of legal cases and my interviews with women who have retracted their allegations of SRA and MPD, I've seen that paying attention to the alters does not always make them disappear. Moreover, these women have made it abundantly clear that some MPD specialists are not ideologically neutral. Rather, they act more like census takers who show up at the door of an apartment and ask: 'Is anyone else in there?'

Is there any justification for this approach? For any approach? Ganaway (1992) has urged the field to conduct a careful review of the standards of practice of mental-health professionals at all levels of education and of all theoretical and technical persuasions. As a research scientist, I would urge more research that might document, scientifically, the more effective way of dealing with dissociative disorder patients who are especially vulnerable. When one particular method of treatment is claimed to be effective, many scientists would feel an obligation to be appropriately skeptical, and to be demanding of such a claim. When dis-

puted claims about therapeutic techniques are made, they ultimately must face the test of science and scientific explanation. As Michael Simpson (1995) so eloquently suggested, science isn't like the caucus race in *Alice's Adventures in Wonderland*. It is not a world where everyone can win and we all get prizes. But it is a world where excessive antagonism is unhealthy, and where respect and open communication are essential.

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References

Allen, J.G. 1993. Dissociative processes: Theoretical underpinnings of a working model for clinician and patient. *Bulletin of the Menninger Clinic* 57, 287–308.

American Psychiatric Association. 1987. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised.* Washington, DC: American Psychiatric Association.

– 1994. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Washington, DC: American Psychiatric Association.

Anastasi, P. 1993. Greek Satanist group accused of killing 2. *International Herald Tribune,* 30 December.

Andres, R., and J.R. Lane. 1988. *Cults and Consequences.* Los Angeles: Commission on Cults and Missionaries.

Appel, W. 1993. *Cults in America: Programmed for Paradise.* New York: Holt, Rinehart and Winston.

Bagley, C., and K. King. 1990. *Child Sexual Abuse.* New York: Tavistock/Routledge.

Beck, A.T., A.J. Rush, B.F. Shaw, and G. Emery. 1976. *Cognitive Therapy of Depression.* New York: New American Library.

Bernstein, E.M., and F.W. Putnam. 1986. Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease* 174, 727–35.

Blood, L.O. 1990. *Satanism and Satanism-Related Crime: A Resource Guide.* Weston, MA: American Family Foundation.

– 1994. *The New Satanists.* New York: Warner Books.

Boon, S., and N. Drajer. 1991. Diagnosing dissociative disorders in the Netherlands: A pilot study with the Structured Clinical Interview for *DSM-III-R* Dissociative Disorders. *American Journal of Psychiatry* 148, 458–62.

– 1993. *Multiple Personality Disorder in the Netherlands.* Amsterdam: Swets and Zeitlinger.

Briere, J. 1989. *Therapy for Adults Molested as Children: Beyond Survival*. New York: Springer Press.

Brown, R. 1987. *Prepare for War*. Chino, CA: Chick Publications.

Brunvand, J.H. 1981. *The Vanishing Hitchhiker: American Urban Legends and Their Meanings*. New York: W.W. Norton.

Bubeck, M.I. 1991. *The Satanic Revival*. San Bernardino, CA: Here's Life Publishers.

Carlson, E.B., F.W. Putnam, C.A. Ross, M. Torem, P. Coons, D.L. Dill, R.J. Loewenstein, and B.G. Braun. 1993. Validity of the dissociative experiences scale in screening for multiple personality disorder: A multicenter study. *American Journal of Psychiatry* 150, 1030–6.

Charlier, T., and S. Downing. 1988. Justice abused. *The Commercial Appeal*, Memphis, Tennessee (series of 15 articles which appeared in January 1988).

Comstock, C.M. 1990. The inner self helper and concepts of inner guidance: Historical antecedents, its role within dissociation, and clinical utilization. *Dissociation* 4, 165–77.

– 1992. Consistency with clinical experience versus sound theory: A response to Rosik. *Journal of Psychology and Theology* 20, 226–8.

Coons, P.M. 1986. Treatment progress in 20 patients with multiple personality disorder. *Journal of Nervous and Mental Disease* 174, 715–21.

Cooper, J.C. 1990. *The Black Mask: Satanism in America Today*. Old Tappan, NJ: Fleming H. Revell.

Courtois, C.A. 1988. *Healing the Incest Wound*. New York: W.W. Norton.

Cozolino, L. 1989. The reality of ritual child abuse. Unpublished manuscript, Pepperdine University.

Daraul, A. 1961. *A History of Secret Societies*. New York: Citadel Press.

Dzeich, B.W., and C.B. Schudson. 1991. *On Trial: America's Courts and Their Treatment of Sexually Abused Children*. Boston: Beacon Press.

Ellis, B. 1992. Satanic ritual abuse and legend ostension. *Journal of Psychology and Theology*, 20, 274–7.

Feldman, G.C. 1993. *Lessons in Evil, Lessons from the Light*. New York: Crown.

Feldman, M.D., and C.V. Ford. 1994. *Patient or Pretender. Inside the Strange World of Factitious Disorders*. New York: John Wiley and Sons.

Fisher, P.A. 1988. *Behind the Lodge Door*. Rockford, IL: Tan Books.

Forst, M.L., and M.E. Blomquist. 1991. *Missing Children: Rhetoric and Reality*. New York: Lexington Books.

Fredrickson, R. 1992. *Repressed Memories*. New York: Simon and Schuster.

Freyd, J. 1993. Theoretical perspectives on the delayed memory debate. Presented at the Center for Mental Health at Foote Hospital's Continuing Educa-

tion Conference: Controversies Around Recovered Memories of Incest and Ritualistic Abuse. Ann Arbor, MI, 7 August.
Freyd, P. 1992. *False Memory Syndrome Newsletter*. 4 May.
Galanter, M. 1989. *Cults and New Religious Movements*. Washington, DC: American Psychiatric Press.
Ganaway, G.K. 1989a. Historical versus narrative truth: Clarifying the role of endogenous trauma in the etiology of MPD and its variants. *Dissociation* 2, 205–20.
– 1989b. Some additional questions: A response to Shaffer & Cozolino, to Gould & Cozolino, and to Friesen. *Journal of Psychology and Theology* 20, 201–5.
– 1992. Some additional questions. *Journal of Psychology and Theology* 20, 201–5.
Geraci, J. 1993. Interview: Hollida Wakefield and Ralph Underwager. *Paidika* 3, 2–12.
Goodwin, J.M. 1989. *Sexual Abuse: Incest Victims and Their Families*. Chicago: Year Book Medical Publishers.
Goodwin, J.M., D. Sahd, and R.T. Rada. 1989. False accusations and false denials of incest: Clinical myths and realities. In J.M. Goodwin, ed., *Sexual Abuse: Incest Victims and Their Families*, 19–36. Chicago: Year Book Medical Publishers.
Gould, C. 1992. Diagnosis and treatment of ritually abused children. In D.K. Sakheim and S.E. Devine, eds., *Out of Darkness: Exploring Satanism and Ritual Abuse*, 207–48. New York: Lexington Books.
Gray, E.T. 1992. *Report of the Virginia State Crime Commission Task Force Study of Ritual Crime*. Richmond: Commonwealth of Virginia.
Griffis, D.W. 1985. *A Law Enforcement Primer on Cults*. Tiffin, OH: ADWG Enterprise.
Grizenko, N., and C. Fisher. 1992. Review of studies of risk and protective factors for psychopathology in children. *Canadian Journal of Psychiatry* 37, 711–21.
Gunderson, J.G., and A.N. Sabo. 1993. The phenomenological and conceptual interface between borderline personality disorder and PTSD. *American Journal of Psychiatry* 150, 19–27.
Hassan, S. 1988. *Combatting Cult Mind Control*. Rochester, NY: Park Street Press.
Herman, J.L. 1992. *Trauma and Recovery*. New York: Basic Books.
Hicks, R.D. 1990. Police pursuit of Satanic crime. *Skeptical Inquirer* 14, 276–86.
– 1991. *In Pursuit of Satan*. Buffalo: Prometheus Books.
Hoch, P.H., and P. Polatin. 1949. Pseudoneurotic forms of schizophrenia. *Psychiatric Quarterly* 23, 248–76.
Hopkins, B. 1981. *Missing Time*. New York: Ballantine Books.
– 1987. *Intruders: The Incredible Visitations at Copley Woods*. New York: Ballantine Books.

Howard, M. 1990. *The Occult Conspiracy. Secret Societies and Their Influence and Power in World History*. Rochester, NY: Destiny Books.

Jeffries, E., B. Willoughby, W.J. Boyko, M.T. Schechter, B. Wiggs, S. Fay, and M. O'Shaughnessy. 1985. The Vancouver lymphadenopathy–AIDS study: 2. Seroepidemiology of HTLV-III antibody. *Canadian Medical Association Journal* 132, 1373–7.

Johnston, J. 1989. *The Edge of Evil: The Rise of Satanism in North America*. Dallas: Word Publishing.

Kahaner, L. 1988. *Cults That Kill: Probing the Underworld of Occult Crime*. New York: Warner Books.

Kaihla, P., and R. Laver. 1993. The ant hill kids. *Maclean's*, 8 February, 18–24.

Kaplan, H.I., A.H. Freedman, and B.J. Sadock. 1980. *Comprehensive Textbook of Psychiatry/III*. Baltimore: Williams and Wilkins.

Kluft, R.P. 1984. Aspects of the treatment of multiple personality disorder. *Psychiatric Annals* 14, 51–5.

Kramer, H., and J. Sprenger. 1971[1486]. *The Malleus Maleficarum*. New York: Dover Publications.

Langone, M.D., and L.O. Blood. 1990. *Satanism and Occult-Related Violence: What You Should Know*. Weston, MA: American Family Foundation.

Lanning, K. 1992. *Investigator's Guide to Allegations of Ritual Child Abuse*. Quantico, VI: Federal Bureau of Investigation.

Larson, B. 1989. *Satanism: The Seduction of America's Youth*. Nashville: Thomas Nelson.

LaVey, A.S. 1990. *The Satanic Bible*. New York: Avon Books.

Loftus, E.F. 1993. The reality of repressed memories. *American Psychologist* 48, 518–37.

Loftus, E., and K. Ketcham. 1994. *The Myth of Repressed Memory: False Memories and Allegations of Sexual Abuse*. New York: St Martin's Press.

Lyon, A. 1988. *Satan Wants You: The Cult of Devil Worship in America*. New York: The Mysterious Press.

McHugh, Paul R. 1993. Multiple personality disorder. *The Harvard Mental Health Letter* 10, 4–5.

– 1995. Witches, multiple personalities, and other psychiatric artifacts. *Nature Medicine* 1, 110–14.

Marron, K. 1988. *Ritual Abuse: Canada's Most Infamous Trial on Child Abuse*. Toronto: Seal Books.

Maury, T. 1987. *The Ultimate Evil*. New York: Bantam Books.

Mayer, R.S. 1991. *Satan's Children: Case Studies in Multiple Personality*. New York: G.P. Putnam's.

Melton, J.G., and R.L. Moore. 1982. *The Cult Experience: Responding to the New Religious Pluralism*. New York: Pilgrim Press.

Metz, G. 1992. *Adolescent Chemical Dependency and Satanic Cults*. Brockport, NY: Institute for Training Professionals and Management.

Michaelson, J. 1989. *Like Lambs to the Slaughter*. Eugene, OR: Harvest House.

Michelet, J. 1995 [1939]. *Satanism and Witchcraft*. Secaucus, NJ: Citadel Press.

Mitchell, J. 1993. Memories of a disputed past. *The Sunday Oregonian*, 8 August, L1–L7.

Mulhern, S. 1991. Embodied alternative identities: Bearing witness to a world that might have been. *Psychiatric Clinics of North America* 14, 769–86.

– 1994. Satanism, ritual abuse, and multiple personality disorder. *International Journal of Clinical and Experimental Hypnosis* 42, 265–88.

Nietzsche, F. 1956 [1871]. *The Birth of Tragedy and the Genealogy of Morals*. New York: Doubleday.

Noll, R. 1992. *Vampires, Werewolves, and Demons: Twentieth Century Reports in the Psychiatric Literature*. New York: Brunner/Mazel.

North, C.S., J.M. Ryall, D.A. Ricci, and R.D. Wetzel. 1993. *Multiple Personalities, Multiple Disorders*. New York: Oxford University Press.

Nurcombe, B., and J. Unutzer. 1991. The ritual abuse of children: Clinical features and diagnostic reasoning. *Journal of the American Academy of Child and Adolescent Psychiatry* 30, 272–6.

Office of Criminal Justice Planning, State of California. 1990. *Occult Crime: A Law Enforcement Primer*. Sacramento: Office of Criminal Justice Planning.

Ofshe, R.J. 1992. Inadvertent hypnosis during interrogation: False confession due to dissociative state; mis-identified multiple personality, and the satanic cult hypothesis. *International Journal of Clinical and Experimental Hypnosis* 40, 125–56.

Passantino, B., and G. Passantino. 1991. *When the Devil Dares Your Kids*. Ann Arbor: Servant Publications.

Pendergrast, M. 1995. *Victims of Memory: Incest Accusations and Shattered Lives*. Hinesburg, VT: Upper Access.

Putnam, F.W. 1989. *Diagnosis and Treatment of Multiple Pesonality Disorder*. New York: Guilford Publications.

Putnam, F.W., J.J. Guroff, E.K. Silberman, L. Barban, and R.M. Post. 1986. The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry* 47, 285–93.

Raschke, A.C. 1990. *Painted Black*. New York: Harper Books.

Ravenscroft, T. 1973. *The Spear of Destiny*. New York: Bantam Books.

Richardson, J.T., J. Best, and D.G. Bromley. 1991. *The Satanism Scare*. New York: Aldine de Gruyter.

Robbins, T. 1988. *Cults, Converts, and Charisma.* London: Sage Publications.

Rogers, Martha L. 1992. A case of alleged Satanic ritual abuse: *In re* B.D., P.A., & K.B., by and through her Guardian Ad Litem, B.B. Plaintiffs vs. Ellen Roe et al, Defendants. Paper presented at the American Psychology – Law Society meeting, San Diego, March.

Ross, C.A. 1984. Diagnosis of multiple personality during hypnosis: A case report. *International Journal of Clinical and Experimental Hypnosis* 32, 222–35.

– 1985. *DSM-III*: Problems in diagnosing partial forms of multiple personality disorder. *Journal of the Royal Society of Medicine* 75, 933–6.

– 1987. Inpatient treatment of multiple personality disorder. *Canadian Journal of Psychiatry* 32, 779–81.

– 1989. *Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment.* New York: John Wiley & Sons.

– 1991a. The dissociated executive self and the cultural dissociation barrier. *Dissociation* 4, 55–61.

– 1991b. Epidemiology of multiple personality disorder and dissociation. *Psychiatric Clinics of North America* 14, 503–17.

– 1994. *The Osiris Complex: Case Studies in Multiple Personality Disorder.* Toronto: University of Toronto Press.

– In press. Alternative hypotheses of ritual abuse. In G.A. Fraser, ed., *The Ritual Abuse Dilemma: Guidelines for Therapists.* Washington, DC: American Psychiatric Press.

Ross, C.A., G. Anderson, and P. Clark. 1994. A trauma pathway to positive symptoms of schizophrenia. *Hospital and Community Psychiatry.*

Ross, C.A., G. Anderson, W.P. Fleisher, and G.R. Norton. 1991. Frequency of multiple personality disorder among psychiatric inpatients. *American Journal of Psychiatry* 148, 1717–20.

Ross, C.A., and V. Dua. 1993. Psychiatric health care costs of multiple personality disorder. *American Journal of Psychotherapy* 47, 103–12.

Ross, C.A., and S. Joshi. 1992. Paranormal experiences in the general population. *Journal of Nervous and Mental Disease* 180, 356–60.

Ross, J.C., and M.D. Langone. 1988. *Cults: What Parents Should Know.* New York: Carol Publishing Group.

Ross, C.A., S.D. Miller, P. Reagor, L. Bjornson, G.A. Fraser, and G. Anderson. 1990. Structured interview data on 102 cases of multiple personality disorder from four centers. *American Journal of Psychiatry* 147, 596–601.

Ross, C.A., G.R Norton, and K. Wozney. 1989. Multiple personality disorder: An analysis of 236 cases. *Canadian Journal of Psychiatry* 34, 413–18.

Ross, C.A., and A. Pam. 1995. *Pseudoscience in Biological Psychiatry.* New York: John Wiley & Sons.

Rotheram-Borus, M.J. 1993. Suicidal behaviors in adult psychiatric outpatients, I: Description and prevalence. *American Journal of Psychiatry* 150, 108–12.

Rush, F. 1980. *The Best-Kept Secret: Sexual Abuse of Children*. New York: McGraw-Hill.

Russell, J.B. 1977. *The Devil: Perceptions of Evil From Antiquity to Primitive Christianity*. Ithaca, NY: Cornell University Press.

– 1981. *Satan: The Early Christian Tradition*. Ithaca, NY: Cornell University Press.

– 1984. *Lucifer: The Devil in the Middle Ages*. Ithaca, NY: Cornell University Press.

– 1986. *Mephistopheles: The Devil in the Modern World*. Ithaca, NY: Cornell University Press.

Ryder, D. 1992. *Breaking the Circle of Satanic Ritual Abuse*. Minneapolis: CompCare Publishers.

Sagan, E. 1974. *Cannibalism: Human Aggression and Cultural Form*. New York: Harper and Row.

Sakheim, D.K., and S.E. Devine. 1992. *Out of Darkness: Exploring Satanism and Ritual Abuse*. New York: Lexington Books.

Salter, A.C. n.d. *Accuracy of Expert Testimony in Child Sexual Abuse Cases: A Case Study of Ralph Underwager and Hollida Wakefield*. New England Commissioners of Child Welfare Agencies.

San Diego County Commission on Children and Youth. 1991. *Ritual Abuse: Treatment, Intervention and Safety Guidelnes*. San Diego: San Diego County Commission on Children and Youth.

Saxe, G.N., B.A. van der Kolk, R. Berkowitz, G. Chinman, K. Hall, G. Lieberg, and J. Schwartz. 1993. Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry* 150, 1037–42.

Schopenhauer, A. 1970 [1851]. *Essays and Aphorisms*. Harmondsworth: Penguin Books.

Schreiber, F.R. 1973. *Sybil*. Chicago: Henry Regnery.

Schwarz, T., and D. Empey. 1988. *Satanism*. Grand Rapids, MI: Zondervan Books.

Simpson, Michael A. 1995. Gullible's Travels, or The Importance of Being Multiple. In L. Cohen, J. Berzoff, and M. Elin, eds. *Dissociative Identity Disorder*, 87–134. Northvale, NJ: Jason Aronson.

Sklar, D. 1977. *The Nazis and the Occult*. New York: Dorset Press.

Smith, M., and L. Pazder. 1980. *Michelle Remembers*. New York: Pocket Books.

Spencer, J. 1989. *Suffer the Child*. New York: Pocket Books.

Steinberg, M., B. Rounsaville, and D.V. Cicchetti. 1990. The structured clinical interview for *DSM-III-R* dissociative disorders: Preliminary report on a new diagnostic instrument. *American Journal of Psychiatry* 147, 76–82.

Stone, L., and D. Stone. 1992. Ritual abuse: The experience of five families. In

D.K. Sakheim and S.E. Devine, eds., *Out of Darkness: Exploring Satanism and Ritual Abuse*, 175–83. New York: Lexington Books.

Stratford, L. 1988. *Satan's Underground*. Gretna, LA: Pelican Publishing House.

Strieber, W. 1987. *Communion: A True Story*. New York: Avon.

– 1989. *Majestic*. New York: Berkeley Books.

Terr, L. 1989. *Too Scared to Cry: Psychic Trauma in Childhood*. New York: Harper and Row.

Terry, M. 1987. *The Ultimate Evil*. New York: Bantam Books.

Underwager, R., and H. Wakefield. 1992. The Christian and satanism. *Journal of Psychology and Theology* 20, 281–7.

Victor, J.S. 1990. The spread of Satanic-Cult rumors. *Skeptical Inquirer* 14, 287–91.

– 1993. *Satanic Panic: The Creation of a Contemporary Legend*. Chicago: Open Court.

Warnke, M. 1972. *The Satan Seller*. Plainfield, IL: Logos International.

West, L.J. 1989. Persuasive techniques in contemporary cults: A public health approach. In M. Galanter, ed., *Cults and New Religious Movements*, 165–92. Washington, DC: American Psychiatric Press.

West, L.J., and P. Martin. 1994. Pseudoidentity and the treatment of personality change in victims of captivity and cults. In S. Lynne and J. Rhue, eds., *Dissociation: Clinical and Theoretical Perspectives*, 268–88. New York: Guilford.

Whitley, G. 1991. The seduction of Gloria Grady. *D Magazine*, October, 45–71.

Wright, L. 1993a. Remembering Satan – Part I. *The New Yorker*, 17 May, 60–81.

– 1993b. Remembering Satan – Part II. *The New Yorker*, 24 May, 54–76.

– 1994. *Remembering Satan*. New York: Alfred A. Knopf.

Young, W.C., R.G. Sachs, B.G. Braun, and R.T. Watkins. 1991. Patients reporting ritual abuse in childhood: A clinical syndrome report of 37 cases. *International Journal of Child Abuse and Neglect* 15, 181–9.

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